"Clinical Studies, in the North Riding Infirmary."

being a

Thesis,

by

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Resident Surgeon.

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late

Resident in Chalmers Hospital Edinr., also in the Edinr. Children's Hospital; also in the Edinr. Maternity Hospital.

Harvey spent almost all my time, since graduation, at a hospital resident, it may be expected that his thesis should contain some new facts in Medicine, Surgery or obstetrics.

It does not, for Two Reasons, —

(1) In my first three hospitals, I was far too busy to travel on original paths; even if it had been available for a newly fledged student. I endeavoured rather to use these as most valuable helps to increasing my clinical knowledge.

(2) Here, again, it is not possible. Not only have I a large no of in patients to attend to, without a single clerk or dresser, the bulk being Surgical, but have, personally, to prescribe for & attend to an out patient department, averaging 50 a Day. This includes Eye Ear & throat cases, which to do conscientiously (eg in the frequent use of the ophthalmoscope etc), take up my whole time. (Harvey in an infant with its mother, I had hoped to estimate these years passed in Early life - till I found that the mother to avoid trouble gave me her own!)

I trust, however, that this thesis will be found to embody (1) the result of much careful Clinical work & Study,

(i) more than one branch of my profession; &
(ii) to contain opinions & methods of treatment gleaned from not a few medical writers, that I have at times studied during my own brief, when it seemed needful. No one can feel its defects more than I do myself.

Contents

I Remarks on Children's Diseases,
including
i. a case of Relapsed Congenital Syphilis;
ii. a case of Hemiplegia + Aphasia;
iii. a case of Laparotomy, for Tubercular Peritonetes.

II Remarks on some of the commoner forms of Dyspepsia, as seen in the out patient department.

III Remarks on some of the diagnostic features in Eye Disease with their treatment.

(These last, I have decided to withdraw, as further experience in eye disease, does not tend, to satisfy me with them)

Case of Relapsed Congenital Syphilis

Amelia H.

Age Six & years.

Admitted March 5th. 1885.

Dismissed August 26. 1885.

Result Relieved.

Relapsed Congenital Syphilis
Before Treatment

R.W. GIBBS & Co MIDDLESBORO

History, including Hereditary Tendencies & Time, Mode & Origin of Present Illness.

Her father, a blacksmith, died a year ago, of "Galloping Consumption", having never been a robust man. Her mother is alive, & states that she is healthy. She seems to be so, though somewhat anemic. Her parents were not related previous to their marriage, at which time the father was 38, his wife 28. During gestation the mother was poorly nourished. The maternal great grandmother & paternal grandfather are still alive. The mother has been five times pregnant with the following results. The first child still born at the full time. The second is the subject of this sketch. She was followed by twins, one of whom is still alive & is 5 years of age & healthy. Two abortions, at the third month, closed her parturient life. The General Surroundings have, to say the least, not been conducive to health.

Previous Illnesses. Has had measles at Christmas time, 1884, but no other exanthem. No history is obtainable of Congenital Syphilis.

Present Illness. The child was fed at the breast until two years old & is stated "never to

have driven Succ vaccination", at the age of 3 months. Three months ago, her face was covered by a skin eruption, which has lately vanished, leaving her face in its present state, v. photo. Since she had measles "her eyes have troubled her;" & it was for this last Complaint that She was brought under my Care. -

State, on admission. -

Alimentary System.

The lips are swollen, specially the upper one, which is so out of all proportion. All the teeth are bad, & the central permanent upper incisors are notched, dwarfed, & planted far apart, but not peg-shaped. The posterior pharyngeal wall is symmetrically congested but there is no definite line of demarcation between it & the healthy tissues*. The tonsils are enlarged. There are no mucous patches. A few slight cicatrices are seen at the oral angles.
The vertical hepatic dulness is just under two inches.

* Cf. Barrett's Dental Surgery. p. 13

* Morrell Mackenzie Diseases of the Throat & Nose. (1910) Vol. I p 88

Haemopoietic System.

The Submaxillary glands are felt, distinctly enlarged

as also the Submaxillary. The Inguinal & Abdominal Glands are normal, no enlargement being detected, even when felt in the manner Dr. Eustace Smith advises[x]. Spleen normal. The bronchial glands give rise to the following physical signs, when the Child's head is held at right angles to the trunk (so that her face looks directly up to the ceiling), a loud blowing murmur is very clearly heard; which murmur becomes less & less distinct as the head is brought forward on to the Sternum. When the Chin touches the Sternum, not a vestige of the murmur is to be heard. There is no dulness over the Sternum or any other part of Enlarged mediastinal glands.

[x] Leading Diseases of Children 4th Edit. p. 316

[+] Treatise on Disease in Children by Eustace Smith 1st Edition. p 183

Respiratory System, does not call for remark.

Integumentary System,

Here there are three distinct sites of eruption; -

(1) On the face there are the remains of an eruption, apparently eczematous, which has left the lip swollen & in a state strongly suggestive of "the Strumous lip"[x], as described by Mr Timothy Holmes, were it not that, (1) the side of the face is also involved, & (11) other Symptoms of a more severe malady. It is fairly clear

[x] Treatise on Surgery 3rd Edit. p 584.

in the accompanying photo.
(II), on the vulva, spreading down the thighs, is a markedly papular, coppery eruption, mixed with a more recent eczematous one. The labia are swollen, like the lips.
(III) A similar syphilitic rash, in the anal region, over the lower part of the sacrum.
The general colour of the skin is dirty yellow, but the face has no "Café au lait" tint.

Urinary System is normal.

Nervous System.

Sight. Here there is extreme photophobia (+ photo), + the Cornea are covered with nebulae + ulcers. There is no interstitial keratitis. (cf Juler's, Ophthalmic Science & Practice, p. 71.)

Hearing. There is no otorrhoea. Otherwise normal.

Diagnosis.

Relapsed, Congenital Syphilis.

Treatment.

She was put on a thoroughly good diet, + it was determined to try the local administration of Mercury.

Therefore March 18 she was ordered

℞. Hydrargyri Oleatis (10 pc)
Vaselini aa p. aequales.

To be applied to the face, several times a day, by means of a brush; & to the vulva & anus to be applied on lint.

also Liq. Atropiae Sulphatis was daily dropped into the eye.×

× Cf. Juler's Ophthalmic Science & Practice p. 55.

Progress

April 8. Weight to day is 2 stone 11 lbs, showing an increase, of 16 lbs, in the space of five weeks. The lip is reduced in size, by one half; & all traces of the eruption, previously seen there, have vanished. The vulva & anal region are almost well. The eye Conditions greatly improved, & much less photophobia. Both sides are thoroughly under the influence of atropine
April 10 oleate stopped to vulva & neighbouring parts as rash has entirely gone. To be continued on the face.
April 25. Swelling of Lip & face much less. Weight 2 stone 10 lbs.
May 19. Every way better. Oleate still being

assiduously applied. Ordered 5ss of Iodide of Potassium ~~twice~~ daily

May 26. Still improving, except for an aggravation of Eye mischief.

Further Treatment.

calls for little remark. The antisyphilitic treatment was steadily pursued until her dismissal with what result the photographs shows. The lip, never sightly, was at least passable - her rashes cured, & her general health greatly improved.

The Eye condition was ameliorated though not cured; ✝the photophobia, such a marked indication of Corneal mischief, had entirely left her.

✝ Nettleship's Diseases of the Eye 3rd edit. p. 92.

Perhaps, I may be permitted to say that a great deal in the treatment of Eye cases depends on two very simple points, (I) Individual attention in applying local remedies & not leaving them to others.

Cf. Juler Ophalmic Science p. 82

(II) Attention to the quality of the drug. This is specially so with Atropia✝ which does not keep well. It has fallen to my lot both here & in the Edinr Children's Hospital to find Eye cases in which the want of improvement was due to neglect of this very simple fact.

✝ Squire's Companion to the B.P. Edition ~~....~~ xiic p. 59. Though Mr Nettleship thinks differently v. op. cit. p. 390.

Remarks.

History.

I have given this at some length, & taken it with extreme care, but I must, frankly, confess that a continued experience of hospital patients (reaching as it now does well into 2½ years), makes me more & more sceptical of their statements. Not only are they quite unable to balance facts, but they often make untrue statements. For example, how common it is to meet cases which inform you that, previous to admission, they have "known up" every thing & retained nothing; who never do so at all, after their admission. In the present case, we are safe in assuming that the father was a healthy man. I do not know that we can safely affirm more, in spite of the well known fact that Syphilis is one of the causes of lung disease.[x] That of the mother is suspicious.[x2] Lastly, that of the child is more so, it has never known disease since vaccination, which remark, though absurd, indicates the

[x] Quain's Dictionary of Medicine p. 900

[x2] Playfair's Midwifery 3rd Edit. Vol I p. 346.

very important fact that the child has always been sickly. More than this, it appears to me impossible to elicit, as to a history of Congenital symptoms, for mothers, of the class, very quickly forget. How often do they observe? A hospital patient, with a tumour, usually waits till it is of some size before he notices comes for advice, whereas the smallest thing makes a private patient come. Once again, if the child had suffered severely from syphilis, in infantile life, she wd., probably, not have been alive to-day. One evidence of this is, that her spleen is unenlarged; which is regarded, by Dr Gee, as a very important point in prognosis[x]. We leave this subject by remarking that the evidence is strongest in the child of its being relapsed syphilis, in where the symptoms are mainly delayed, till the 7th or 9th year.[x1] [x2]

[x] Lumleian Lects: Treatise on Diseases of Children p. 205

[x1] ditto. p. 211

Alimentary System

Here important evidence is given by the

notched & dwarfed permanent central upper incisors - symmetrically so in this child - though this is not invariable [x1]. In fact, it appears that these teeth are the only ones which give reliable evidence of syphilis, not being due to mercurial stomatitis [x2]. In this view, Mr Nettleship quite concurs [x3]; in which he is followed by Mr Lawson [x4].

[x1] E. Smith. Wasting Diseases of Children 4th edit. p. 182

[x2] Holmes op. cit. p. 390

[x3] Nettleship on Diseases of the Eye 3rd edit. p. 313

[x4] Diseases of the Eye: Lawson. 4th edit. p. 30

The fact that the liver is enlarged is like that of the spleen, favorable, thus Eustace Smith remarks that if it is, death results soon [x5].

[x5] Wasting Diseases of Children p. 188.

Haemopoietic System.

The glandular enlargements, by their site, strongly point to syphilis as the factor in their production. The only moot point is as to the possible enlargement of the mediastinal glands. Before making such a diagnosis, it is needful to investigate the following points.

i The presence of an exciting cause eg repeated pulmonary catarrhal attacks.

ii Pressure Symptoms on (a) the veins causing venous engorgement

(b) nerves causing paroxysmal cough, or (if far advanced) altered voice.

(c) air passages, causing dyspnoea.

III. Physical signs. (a) dulness on percussion over the first bone of the sternum, if the enlarged glands be in actual contact with the breast bone.

(b) various auscultatory signs, of which the most important has already been described, (V.A. System) is the bruit. It is thus produced, — First of all, it is well to remember that for the production of a venous bruit, (such as this is), 2 factors are essential, (a) relative constriction, (b) a certain amount of force[x1]. Now in this case, the left innominate vein is pressed forward by the trachea against the first bone of the sternum. Between the trachea & the vein are situated the enlarged glands & these compressing the vein produce the bruit.[x2] It is essential for its production that neither the lower end of the trachea or the glands, lying below its bifurcation, be fixed[x3]; & also that the head be bent backward, as thereby the lower end of the windpipe is tilted forward; for as the head is brought forward on the thorax, & the trachea thereby not tilted forwards, the murmur becomes less distinct

[x1] George Balfour "Diseases of Heart & Aorta" p. 169 (3rd edition)

[x2] Eustace Smith. "Wasting Diseases of Children" 4th edit. p. 310

[x3] vide a very remarkable case cited in Smith's large work p. 183

How a careful investigation of all these points reveals but one feature,- the heart, & therefore I think we are hardly justified in diagnosing any extreme enlargement of the bronchial glands.

Respiratory System

The fact that the temperature is normal excludes a diagnosis of Tuberculosis. In fact, nothing is more characteristic of Tubercle than a subnormal morning temperature, with a great rise in the Evening [x1].

[x1] Eustace Smith Wasting Diseases of Children 4th Edit p. 258

Integumentary System

We notice here, (I) a pale dirty colour of Skin, (described by Liveing [x2] in speaking of acquired Syphilis) due to (a) anaemia (b) pigmentary Changes; (II) the well known coloured, "raw ham like" or "coppery" much more usual late on in Syphilis [x3]; (III) in the macules though unsymmetrical they are on both sides of the body; (IV) a total absence of itching all the more striking in a child, (V) the time of appearance these Smith remarks "In rare cases the Symptoms of hereditary Syphilis are delayed till the 7th or even 14th year" [x4].

[x2] Liveing's Diseases of the Skin 4th Edit. p. 270

[x3] ditto p 270.

[x4] Special Surgery p. 182

Nervous System

The extreme photophobia is well seen in the photographs. This being overcome no specially characteristic Syphilitic change is found. Such as iritis[x1] or interstitial keratitis[x2] The same may be said of the aural conditions, which is satisfactory as hereditary Syphilitic Ear disease is not very uncommon[x3].

[x1] Lawsons Diseases of the Eye 4th edit p. 84
[x2] ditto p. 30.
[x3] Guide to the Study of Ear Disease McBride p 188.

Diagnosis.

This could only lie between two things, Struma & Congenital Syphilis. I shall here tabulate the facts in favour of each

Syphilis

i History — There is no obtainable one of congenital symptoms at birth, but the mothers history[x4] is suspicious, to say the least.

ii Cachexia — —

iii Epithelial Development — —

iv Glandular Development — Points entirely to syphilis. with the solitary exception of the possible enlargement of the mediastinal glands, & this as we have previously seen is doubtful.

Struma

Facts might be taken, as previously stated.

The child has had measles, a very great developer of struma, provided the seed is there[x5] Entirely absent[x6]

It is possible that struma & syphilis may occur in the same subject If so, this would Guide explain the result[x7]

[x4] Hart & Barbour's Manual of Gynecology p. 615
[x5] Pinteaus Smith Retd p. 174.
[x6] ditto p. 176
[x7] ditto p. 174.

Relapsed Congenital Syphilis
After Treatment

R.W. GIBBS & Co MIDDLESBORO

	Syphilis	Struma	
V Condition of Bones & Joints	In this case negative. There is no Periostogenesis or Osteochondritis ×2	no evidence of any marked condition ×	×1 Ellis' Diseases of Children 4th edit. p. 35 ×2 J. Smith Diseases in Children p. 206.
VI Skin eruptions	Colour & site favours this ×3	—	×3 Holmes Syst. vol p 383
VII Teeth	are almost Conclusive ×4	—	×4 Quain's Dictionary of Medicine p. 1595
VIII Facial appearance	The flattened nose & cicatrices are very striking	It is not that of a strumous child ×5	× Fothergill Practitioners Handbook 2nd edit. p 258.
IX Temperature		Excludes any possibility of glands Suppurating	

A careful consideration of these facts I think, settles the diagnosis as Congenital Relapsed Syphilis & all the more as the case is improving under anti Specific remedies. I would Specially refer to points VI. VII, VIII.

Treatment.

Once grant that a case is Syphilitic, & the Question at once presents itself Should Mercury be given or not. And here as far as I can

however surgeons may differ about the propriety of giving it in acquired Syphilis, they advise it, without one dissentient voice, in case of Congenital Syphilis, as this is. Thus Mr Holmes writes, "mercurial treatment is urgently indicated."[1] Mr Erichsen fully endorses this, "mercury, which in these cases, acts almost like a specific."[2] So also, Dr Milner Fothergill[3]. So also, Dr Morell Mackenzie, who says "although in many cases of constitutional Syphilis, in adults, I do not consider that mercury is necessary, yet, in this form of the disease, mercurial treatment appears to me, the best that can be adopted, the administration of this drug having a very marked influence on the duration & intensity of the affection"[4]. Mr Cooper is equally clear & decisive, — "Mercurial treatment should always be adopted."[5] Professor Spence taught the same in no uncertain tone[6].

After such testimonies as these, no one can deny the propriety of exhibiting it in the present case.

The next Question, that arose, was as to the best method of administration. I cannot do better than enumerate them, as given by Dr Bartholow[7]

1 Injection. 2 Fumigation

[1] Holmes Treatise on Surgery 3rd edit p 389.

[2] Erichsen's Science & Art of Surgery 7th edit. Vol. I p. 877

[3] Practitioners Handbook of Treatment 2nd edit. p. 161

[4] Morell Mackenzie's Diseases of Throat & Nose Vol II p. 407

[5] Quain's Dictionary of Medicine p. 1584.

[6] Spence's Lectures on Surgery 2nd edit. p. 136.

[7] Bartholow's Materia Medica 4th edit p 237

3. Hypodermic Method. 4 Internal.

Once again, in Infantile Syphilis, there seems no difference of opinion as to inunction being the best method, hence its selection in the present case.

It remained to consider the most suitable preparations for inunction. Previous experience made me resolve to try the oleates, all the more as Ringer – in his rose coloured book on Therapeutics – quotes Mr Marshall's strong recommendation "Again in many of these syphilitic affections, for the cure of which mercury is applicable, the oleate of mercury preparations offer some advantages".[x1] They are, in truth, much more cleanly than the old fashioned blue ointment (unguent. hydrarg)[2], so often advised for a similar purpose[x2]. There are three strengths, the 5 p.c; 10 p.c & 20 p.c[x3], of which the 10 p.c. is generally employed diluted with equal parts of vaseline. Moreover, they are usually lightly applied by a brush as in the present case[x4].

I do not intend here to refer to the eye treatment.

The above treatment was carefully carried out until May 19, when she was ordered in addition

℞ Potassii Iodidi
Ferri et Ammoniae Cit aa ℈i
Aquae ℥ii
Sig. ʒß ter in die

[x1] Ringer's Handbook of Therapeutics 9th Edit p. 267

[x2] vide Farquharson's Guide to Therapeutics 3rd Edit. p. 112

[x3] The Extra Pharmacopoeia 2nd Edit. p. 189.

[x4] Ringer op. cit. p 265. & also Allen Smith, on Ringworm, Edit II p. 105

This last combination is specially useful in such cases, I suppose, most medical men prescribe a similar remedy every day. For my own part I confess I owe the formula to Mr. Lawson[x]. And in such young subjects, preliminary purgation is hardly so essential, before a course of iron, as it is in Anæmic young women.

[x] Lawson's Diseases of the Eye 4th Edit. p. 392.

[x²] Hart & Barbour's Man. of Gynecology p. 618.

As is stated, elsewhere, she went out better in every way. More cd not be expected. It is not possible to Eradicate Congenital Syphilis. One sign was all persistent as ever, & that was the local Nervous tumor over the first bone of the Sternum; but no further signs ever showed themselves. And, as is the case with so many hospital patients, it is too probable that a short residence, outside, may reduce her to a Condition similar to that which induced me to write this imperfect sketch, though the diagnosis is fortunately unconfirmed by that Crucial test, — a post mortem Examination

Nov. 1885. On the Contrary, She improved still more,

vide photo III

over

The same child, still later, Nov 1885.

R.W. GIBBS & Co MIDDLESBORO

Mary K. age 9.
admitted April 6. 1885-
Discharged. June 30.
Result. Improved.

Disease, Right Sided Hemiplegia, with Aphasia.

DISEASE.

Right Sided Hemiplegia & Aphasia

Notes of Case.

Name { Mary Kane

Age 9.

Diet Ordinary

Case Book No.

May 7.

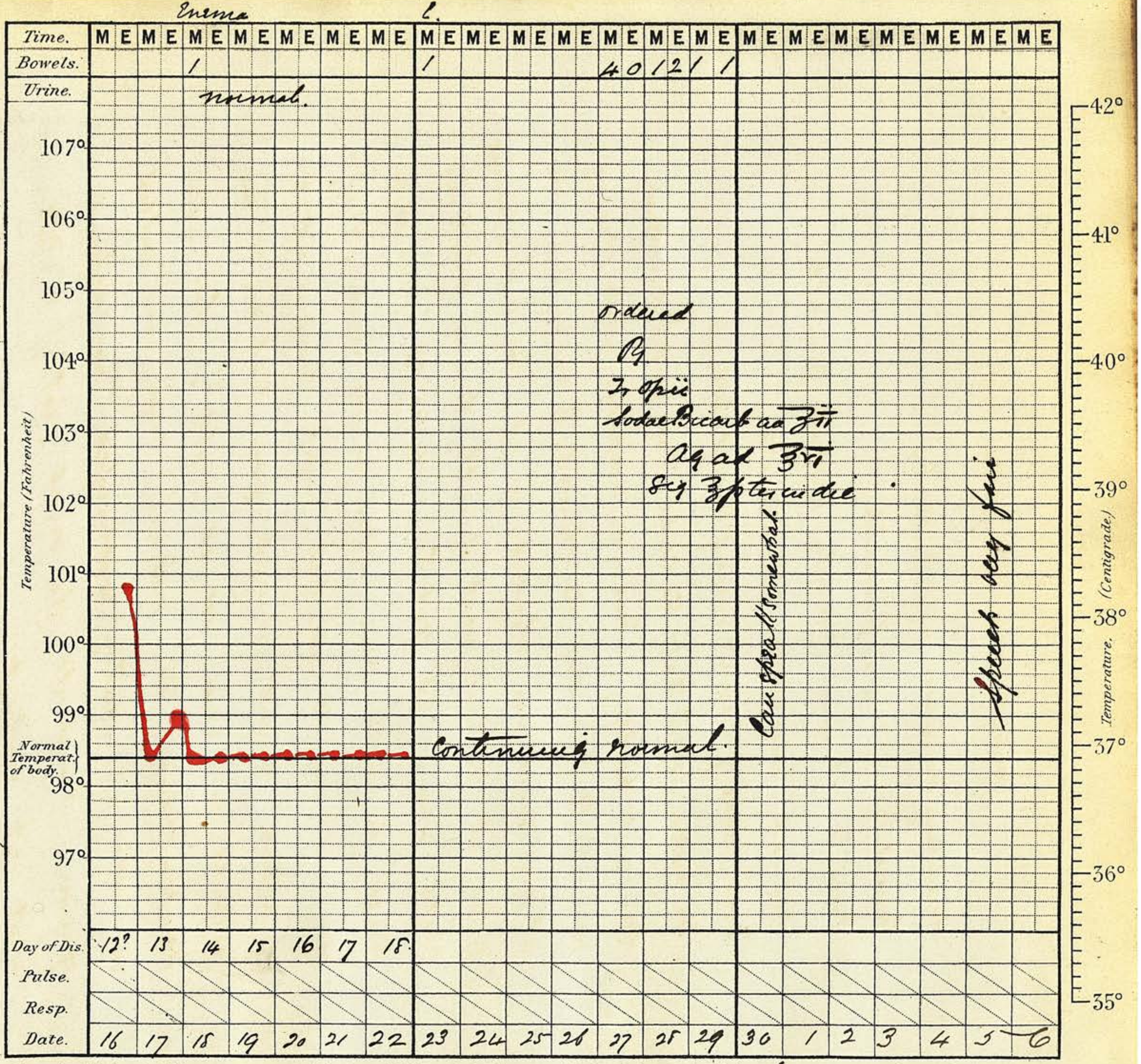
Rx.

Sodae Bisulph. ʒii

Aqua ad ℥vi

Sig.

ʒß ter in die



Date of admission. April 16.

Result Relieved.

Entered at Stationer's Hall. Printed and Published by Wodderspoon & Co. 7, Serle Street, Lincoln's Inn. Gould's Clinical Chart

History. Date April 20. 1885

Hereditary Tendencies unimportant.
General Surroundings, favourable.
Previous illnesses. Has only suffered from "colds".
Has had none of the Exanthemata.
Time, Mode of Origin & Course of Present Illness.
The mother states that the child has, until this illness, been quite healthy. Five or six weeks ago, while playing near a publican's shop, she chanced to annoy him. He at once seized her & locked her up. Her mother hearing of this, at the time, went directly to him & took her child home. At that time, the Child appeared as though "she would have dropped in her hands". She remained very ill, all that night, being in a state of intense fright. And from that day to this the Child has never seemed "right". Soon after the mischance, the medical man was called in who, apparently, vouchsafed no definite opinion. Though ill, she varied greatly & still went out & about, one day fit for school, the next not, generally preferring great quiet. At this time, the neighbours frequently said the Child was going into S. Vitus' dance, but it appears that neither medical man nor mother saw any of its familiar Signs. Then "moping" habits Continued until April 14. On that day, she went out with

her mother, who noticed nothing out of the way about her, until "all of a sudden she fell down in the street," — unconscious. She was carried home, & has remained ever since in a similar condition, i.e. unable to speak or to move her right arm or inferior extremity. Further inquiry showed she had had an attack of rheumatism. [I may remark that it was extremely hard to elucidate even the above imperfect history]

State on Admission.

General Facts.

The child lies in bed unable to move her right arm & leg. Over her malar bones, there is, on both sides, a bright flush which does not easily disappear on pressure. She looks extremely frightened, like a hunted animal. The face presents the usual appearance found in right hemiplegia, hereafter to be described. —
There is no evidence of any Special diathesis.

Circulatory System,

On Inspection & Palpation nothing abnormal can be detected; but the right border of the deep cardiac dulness is found half an inch outside the sterno costal margin, & extended from thence to the left nipple line, measuring transversely 4 inches*. This certainly, I think, warrants

cf. Balfour Dis. of the Heart Vol II p. 17.

the presumption that the heart is enlarged, for I believe that very much the same rules apply to the percussion of a child's heart as to that of an adult. Though every one does not concur in this remark; for, I remember, one of the physicians in the Edwin Childrens Hospital, telling me, we had no definite data for the percussion of a child's heart. Though in many children the apex beat position should be noted, remembering that the nipple is lower in them.*

E. Smith op. cit- p. 551

On Auscultation, a loud blowing systolic murmur is heard over the whole front area, but most distinctly & loudly over the mitral valve. It is heard, clearly, at the inferior Scapular angle. The pulmonary 2nd Sound is accentuated*

cf Graham Steell Physical Signs of Cardiac Disease p. 40. also Balfour's Diseases of the Heart. Vol II pp. 31 & 144

Respiratory
Integumentary &
Genito Urinary Systems do not call for remark. There is no albumen or other sign of backward pressure.

Nervous System.
The case being (a) young, (b) aphasic, & (c) timid, it was not possible to glean much from it.
Sensory Functions.
These appear normal. She is quite able to distinguish

reaction of degeneration.

Vaso. Motor Functions. The right hand & foot are often noticed to become purple.

Cerebral Functions. There is almost total loss of speech. The child is only able to say yes & that indistinctly. While taking these notes, I was not aware that "Children as a rule say "yes" long before they say "yes"." cf. Gowers Diagnosis of Brain Diseases p. 129.

Provisional Diagnosis

Right sided Hemiplegia with Aphasia due to Embolism of the left middle Cerebral artery. cf. Gowers op cit. p 50

Remarks.

The fact of not having previously seen Hemiplegia & Aphasia, in a child, induced me to take the above notes. I mainly wish - in this relation - to consider the Nature, Seat, & Cause of the Lesion.

I Nature. Few would I think deny that we have here a case of Cerebral Hemiplegia. It is not Spinal for the following reasons. (1) The face & tongue are paralysed. (11) There is distinct derangement of Cerebral function. (111) There is marked anesthesia. cf. Byrom Bramwell's Diseases of Spinal Cord Edit II p. 151

(IV) There is no rapid atrophy of the muscles.

(V) There is no evidence of the usual causes of Spinal Hemiplegia, (Eg injury or compression of the Cord).

II seat. Now, in almost every recognised text-book, it is clearly laid down that right sided hemiplegia, (which is far commoner than left), along with aphasia is caused by a lesion of the posterior part of third frontal Convolution, or else the wedge of white matter extending thence to the Corpus Striatum"

vide Treves Surgical applied Anatomy p. 31

vide Reichert's Theory & Practice of Medicine Edit III p 895

Though, I am not unaware of Dr Eustace Smith's remark, - "that in the young subject, aphasia may be present though the Brain is free from disease*". Here, however, we have Hemiplegia combined with Aphasia; & cannot I fancy doubt the presence of a Cortical brain lesion. Certainly, I shall not have the hardihood to deny the dictum laid down as to its probable site. It is, I think, in a child, neither possible or prudent for me to venture a more exact opinion as to the probable ~~Site~~ part of the part of the Corpus Striatum involved.

* vide Eustace Smith's "Diseases in Children p. 263.

Though it seems but fitting to state, in this place, that the Corpus Striatum is now known to be of Complex Composition, to wit, of "two masses of grey matter separated from each other by the white peduncular fibres of the inner Capsule, which pass upward through its substance," (a) nucleus Caudatus & (b) nucleus lenticularis"

V. Prof Turner's Introduction to Human Anatomy Revised Edit. p. 250.

the former being comma shaped, the latter being like a prism[x]. "In horizontal section the internal capsule seems to consist of two oblique parts, which join at an angle; the anterior segment or "limb" as it is termed, lies outside the body of the Caudate nucleus, the posterior outside the optic Thalamus, & the angle or knee lies between the thalamus behind, & body of the Caudate nucleus in front." External to the lenticular nucleus is the external capsule, one band of the bundle of Reinier. Externally imbedded in it is the Claustrum which is an extremely thin plate, or (as described in Quain) "a thin lamelliform deposit of grey matter"[x]. Next, comes Reil's Island. Most fibres occupy the elbow & anterior 2/3 of the posterior segment[x]. The posterior 1/3 contains sensory fibres, & the anterior segment contains fibres of uncertain origin. But it is not my intention or desire here to describe fully the anatomy of these parts. I merely mention them, briefly, because, nowadays, it is known that the symptoms & result of affections of the Corpus Striatum vary according to the part affected, & that in lesion of the External or internal Capsules the hemiplegia persists & is followed by secondary changes; whereas it is the converse if the

[x] vide Prof. Hamilton's Pathology Lectures Winter Session 1880-1881

Gowers Diagnosis of Brain Diseases [x] p. 14.

[x] vide Bristowe op. cit. p 873.

[x] Quain's Anatomy 8th Edit. Vol III p. 564 & 568.

Caudate & lenticular nucleus suffer, the hemiplegia not being lasting & not being followed by secondary degenerations. In the present case I shall not give a more precise diagnosis than that the Corpus Striatum & third frontal are affected leaving it to time to settle the permanency or non-permanency of the lesion.

III Cause.

This can be but one of Two Things either

A. Haemorrhage or
B. Embolism.

"Haemorrhage is almost always due to rupture of an artery very rarely to that of a vein". Under embolism we do not include thrombosis though the two processes are sometimes mixed up. "Embolism is the result of a morbid process — commonly in the heart. Thrombosis is the result of a local disease of the artery".

× Gowers. op. cit. p 187

cited p. 191

I shall put side by side their distinguishing features

	Haemorrhage	Embolism.
I Causes. E.g. Previous predisposing Diseases	× This is usually due to Chronic Bright's Disease or degenerative arterial changes.	In the present case, we have no evidence of any such causes. The urine is normal

× vide Brisbow op. cit. p 1000

[1] Briscowe op. cit. p. 1000 (cf. Gowers op. cit. p. 207)

[2] ditto p 1011

[3] ditto p. 1011 cf. Gowers p 207.

[4] Tweedies Dictionary of Medecine p. 1574

[5] ditto p 1574.

[6] ditto p 1444 cf. Gowers p. 212

[7] J. Eustace Smith on Diseases in Children p. 552 + 551

Causes
E.g. age.

[1] **Hemorrhage**
is common, only, after 40. indeed it is most rare under this age.

Embolism.
This case is 9 years old & "embolism may occur at any period of life; yet is most common from puberty upwards" [2]

Causes
Eg heart disease

[3] "Embolism is — the consequence of rheumatic inflammation of the valves of the heart."
In the present case, we have a rheumatic history & well marked mitral disease

---

III Progress
Eg improvement

at the time of writing the aphasia is recovered from (May 16)

[4] "Improvement occurs earlier than in central hemorrhage.

Progress
Eg Temperature

vide Chart.

[5] Here close Soore

III Symptoms
Eg Embolism Elsewhere

[6] none detected ie pelvis or Spleen

Eg examination

[7] "In all cases where Hemiplegia occurs, suddenly, in a child, direct attention to the heart"

A consideration of these diagnostic points leaves little room for doubt that the diagnosis of Embolism is correct. The source of the Emboli is, most probably, the crippled mitral valve. It remains, merely, to state the artery in which it is impacted. And this certainly is the left middle cerebral, supplying, as it does, the "corpus striatum"[x] (by its anterior branch) the third frontal convolution, the anterior cerebral not supplying this special tract. Such a diagnosis covers, I think, all the facts found in the case. explaining even the vesical symptoms. For, once more, to quote Dr. Bristowe[x], "other symptoms are generally associated with these namely loss of control over the bladder & rectum, & the like".

Artery of Impaction

[x] Gowers op. cit. p. 159

Bristowe's Theory of Medicine 3rd edit p 1013

Progress & Treatment.

May 7. Having recovered from an intercurrent attack of diarrhoea (vide chart), she was placed on Bisulphite of Soda, which is mentioned by Dr. Eustace Smith[x2], though by this time, the symptoms had improved somewhat. Naturally I was

[x2] op. cit. 554

not - could not be - hopeful of any drug treatment. Indeed it is hard to believe that medicine will ever be able to do much for the treatment of cases like the present. Still of drugs generally, I more & more am of opinion - that Lord Halifax's famous motto holds true - "in medio tutissimus ibis." There is, certainly, too great a tendency in the present day to therapeutic nihilism - an opinion held also by an Eminent writer like Dr. Bartholow.[x]

(The quotation is of course from Ovid).

[x] vide Bartholow's Practice of Medicine 2d ed. p xii of preface

May 15th. Has begun to move the inferior extremity. She continued to improve, being removed on June 30, by her parents desire, at which time, her condition was as follows.

Circulatory System.

The mitral systolic murmur is as clearly heard as ever, indicating a permanent change in the mitral Cuspis; & rendering it possible that, at any time, another Embolus may be swept into the blood current.

Nervous System.

Motor Functions

Nutrition & the Reflex functions are now normal. The reflexes are to be obtained on the affected side

& The Superior & Inferior ~~extremities~~ are much improved in power - Specially the latter, as regard speech. Her grasping power is not good; but the extensors of the wrist & fingers are feeble, The wrapping up of the affected muscles - in cotton wadding - as insisted on by Mr Henry Lee - (of The Great Ormond St. Children's Hospital), has greatly improved them. Facial Muscles, normal.
Cerebral functions. Speech almost normal.

Closing Remarks.

need not be many.
The rapid return of speech is in accordance with Dr Gowers statement; "Permanent aphasia, in Children, from disease of the left hemisphere, is almost unknown." × Gowers op. cit. p. 135

It has, lately, followed the course so ably sketched by Dr Bastian, - "× of these Symptoms the thickness of Speech - the deviation of the tongue the paralysis of the face & the diminished sensibility soon either grow perceptibly less or actually disappear;" & again in all cases however slow the recovery of Power usually shows itself in the leg sooner than in the arm, & the muscles about the joints nearer the body are in each case called into action before those moving joints which are more remote" × Vide Isaacs Dictionary of Medicine p. 1095 et seq.

The condition of the muscles is altered, as usually so, by Dr Bristowe.

Bristowe op. cit p 900

Finally, although, happily, the child has gone out improved & the diagnosis is not verified by, that crucial test, a post mortem Examination, yet, I think, her progress has justified the diagnosis

A similar case is described by Eustace Smith, differing in the fact of a more rapid recovery†.

E Smith op. cit p. 552

Remarks on a Case of

Tubercular Peritonitis,

for which, Laparotomy was performed.

John B. Male aet. 8.

Admitted. June 9. 1855

Died Aug. 5 1855

Result. Died.

DISEASE.

Tubercular Peritonitis

Notes of Case.

Name { John Burton.

Age 8.

Diet Special

Case Book No.

℞ Bismuth 9ss 10.
Pulv Cret. Co. aa 9ss 5.
M pulv.
Sig. one three times a day.

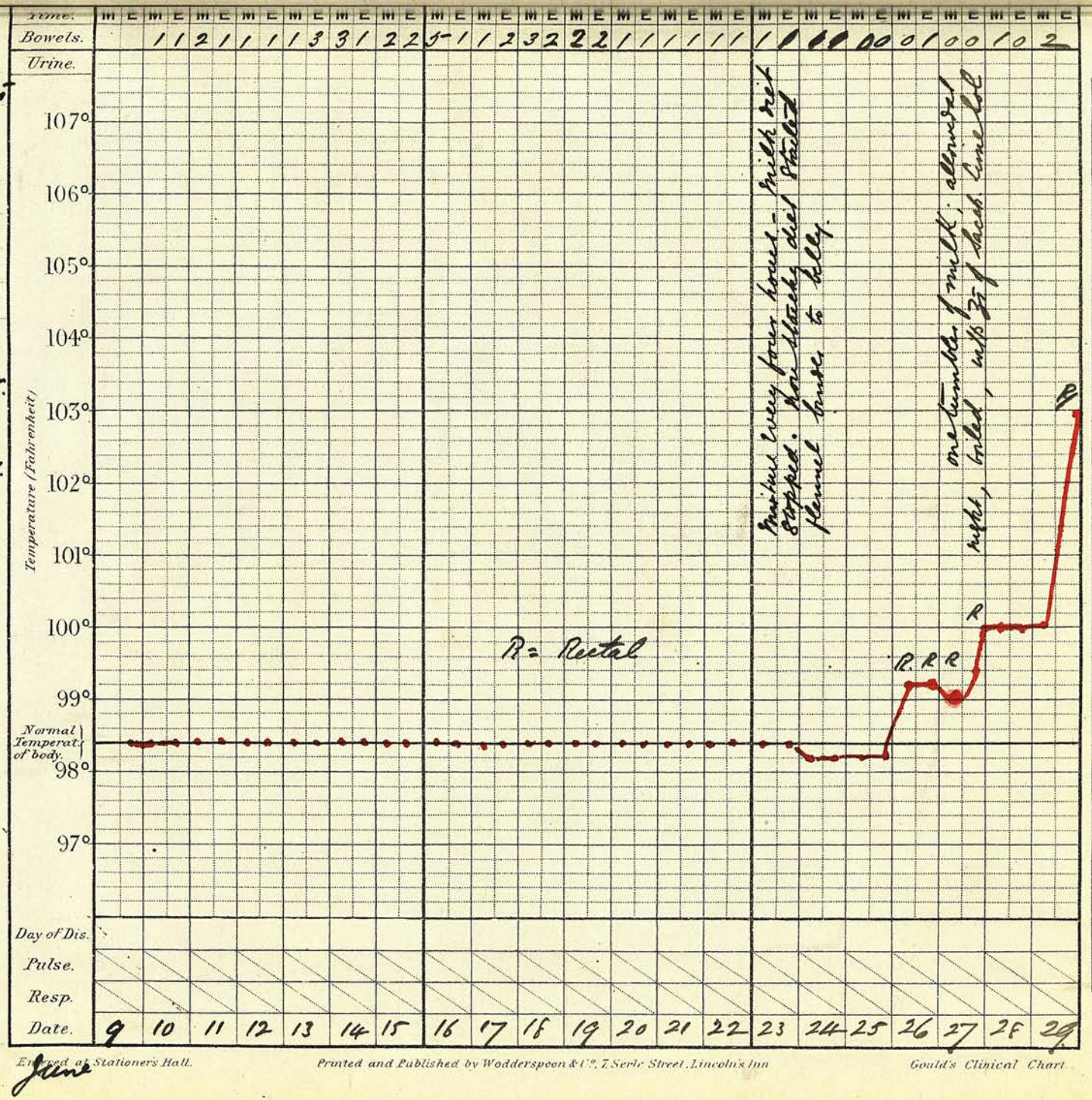
June 22.

℞ Tr. Opii 3ss
Sodae Bicarb 3ii
Aq ad 3iv
Sig. 3ss ter in die

June 23.
Every 4 hours.

Date of admission. June 9.

Result died



Entered at Stationers Hall. Printed and Published by Wodderspoon & Co. 7 Serle Street, Lincoln's Inn Gould's Clinical Chart

DISEASE.

Tubercular Peritonitis

Notes of Case.

Name { John Biloe

Age Light

Diet Special.

Case Book No.

℞.

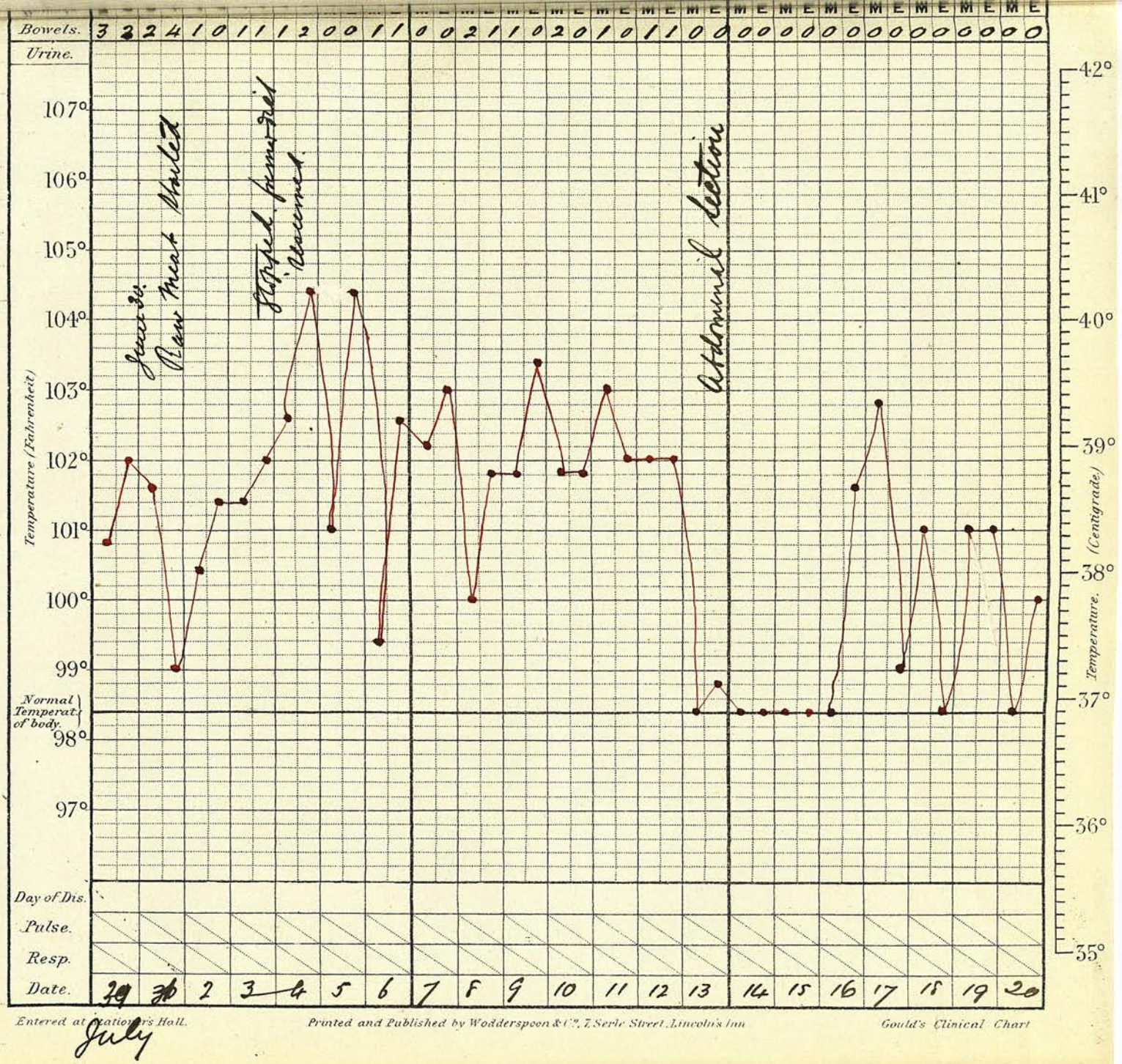
Tincturae opii ℥ℓ
Sodae Bicarbonatis ℥ℓ
Aq ad ℥ℓ

Sij. ℥ß every 4 hours.

Date of admission.

June 9

Result P



Entered at Stationers Hall.

July

Printed and Published by Wodderspoon & Co., 7 Serle Street, Lincoln's Inn

Gould's Clinical Chart

DISEASE.

Tubercular Phthisis

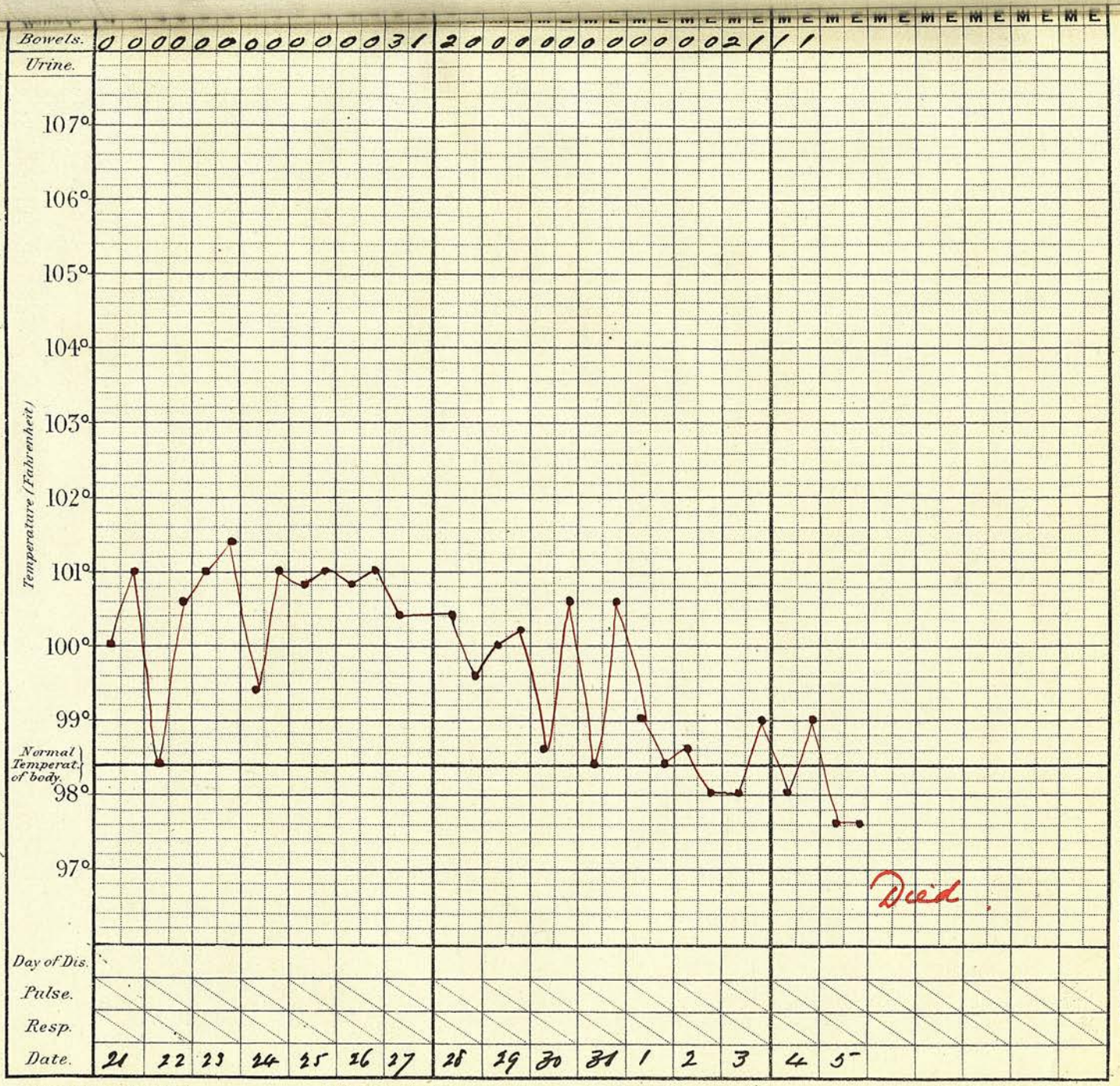
Notes of Case.

Name John Bilotti

Age 8

Diet Special

Case Book No.



Date of admission.

June 9.

Result Died

Entered at Stationers Hall. July

Printed and Published by Wodderspoon & Co. 71 Seale Street, Lincolns Inn Aug.

Gould's Clinical Chart

In his work, on Intestinal Obstruction, Mr. Frederick Treves writes, as follows, "Apropos of this subject, it may be observed that the practice is gaining ground of treating many cases of peritonitis by free incision & drainage. This treatment has been applied to inflammatory effusions into another large serous cavity, that of the pleura, & why not to the peritoneum? The cases that appear to be best suited for such treatment are, cases of chronic peritonitis, & especially of local peritonitis. So far as I can ascertain, the first serious proposal that abdominal Section should be performed for peritonitis was brought forward by the late Mr Hancock, in 1848."

x Intestinal Obstruction by Frederick Treves. 1884. p. 465

I propose - briefly - in the following pages to give a few facts about a case - in the Rock Riding Infirmary - in which the above treatment was pursued. I only regret that illness & other Causes prevent them being fuller.

John B - aged 8 - was admitted on June 9. His father was Coloured, his mother white. No definite history was obtainable, save that of long ill health. It was evident, however, that the boy suffered from some

abdominal trouble as the belly was greatly distended; moreover he suffered greatly from persistent diarrhoea.

On Exam^{n} of the Abdomen.

Inspection + Palpation revealed little; but the fact that the tenseness of his recti + abdomen generally prevented any considerable pressure - in itself was suggestive of some abdominal mischief.

Percussion gave a tympanitic note over most of the cavity - impaired at the lower part. Just at umbilicus, 21 inches. Urine alkaline - no albumen or microscopical deposit. Other systems apparently normal.

I propose to consider a few of the commoner causes of, -

Abdominal Distension.

I Ascites

although we are dealing with a child yet it is difficult to give a better statement of the physical signs of this disease, than that given by Hart + Barbour, "* When on the back percussion gives a tympanitic note at the umbilicus + a dull one at the flanks, when on the left side, the note is dull on that side + clear over the right; when on the right side, vice versa: when sitting up the upper limit of dulness is raised".

* Hart + Barbour's Manual of Gynecology. Edit I. p. 208.

Certainly, the present was not a case of ascites.

The abdomen is, of course, distended in many other complaints (eg acute peritonitis - typhoid fever, etc) of which tabes mesenterica is by no means a Common one[x] . The commonest cause is,

II Flatulence[x2],

which is, usually, due to distension & derangement of the intestinal canal.

III Tubercular Peritonitis, of which the following are useful diagnostic points;

(a) an insidious commencement,

(b) very important is the effect of a sudden jar[x3]. A sudden jump usually - not always - hurts such cases.

(C) temperature[x4], which is always higher in the evening. Perhaps this is the most important feature of its tubercular character. I well remember this - in the Edenr Children's Hospital - where at the Secti - general tuberculosis was often found -, of which the main sign during life had been a subnormal morning temperature along with an Evening rise.

(d) physical signs, a large belly - tender - unequally resistant, with indistinct fluctuation are the rule, though not invariably so.

[x] vide Dr Ellis Diseases of Children 2nd Ed p. 391

[x2] & Smith's Diseases in Children p. 702

[x3] vide E Smith's Diseases in Children p. 695

[x4] vide E Smith's London Diseases Edn IV p. 258.

Now, it was in the last named disease that the present case was classed - though only by degrees - for, at first, very few of the symptoms were obtainable, (vide report on admission). But a study of the accompanying Charts will show that, by degrees, the temperature rose at night - specially noticed when taken per rectum. By degrees, the physical signs resembled what I have just described, but pumping never elicited any Complaint of pain. So that it was finally classed as such - all the more so - when, in about four weeks, after admission - the lungs showed slight indications of breaking down. One very troublesome feature was

The Diarrhoea. (vide Charts)

which was treated here. [Two points are of great value in this relation (a) the frequency & (b) Character of the motions. The former point is settled by a glance at the accompanying Charts; the latter is best stated in Eustace Smith's words "the evacuations Consist of thin dark offensive fluid or of equally offensive pasty matter & mucus"×. As Dr Ralfe remarks, "those who make it their duty to inspect the stools of patients soon learn to recognise all odours, sui generis."× Perhaps, I ought to say that I quote Eustace Smith's office

Op. Cit. p. 633

Ralfe's Clinical Chemistry p. 221

on Childrens Diseases - because, I know of no other writer so lucid or so good as he is. After carefully weighing many other similar works, such as Dr. Lewis Smith's. Dr. Ellis; Meigs + Pepper or Sewell, I find none which can compare with his clear + pertinent statements. This, by the way.]

June 10.

The child was put on a diet limited to skim milk, guarded with lime water; & powders of Aromatic Chalk + Bismuth. Skim milk was selected because it is milk "deprived of a certain amount of its fatty constituents"*. The latter Cream was given in large doses - as it must always be - if its mechanical action is to produce an effect.

*Parry's Treatise on Food 2d ed II p. 190

June 22.

Matters seeming but little better, & the child wasting - as patients so often do - of milk; it was decided to stop it entirely + put it on a diet, from which milk was strictly excluded This consisted, of the yolk of an egg for breakfast along with dry toast + butter;

dinner of an underdone Chop with greens; & the evening meal of beef tea or repetition of breakfast. His belly - measuring at this time 21 inches, was wrapped in a flannel bandage; & he took, as medicine, a combination of bicarbonate of Soda with Laudanum. Under this, he improved, until June 30, when diarrhoea again set in with renewed activity.

June 30. He was now tried with raw pounded meat, but in spite of great persuasion & giving it in various disguises, he'd never be induced to take it properly, & it had to be discontinued, after a few days trial. He returned to his previous Non Starchy diet.

The temperature was now very unsatisfactory - the diarrhoea only partially checked & the Childs Condition also very unsatisfactory, many Symptoms now showing themselves, (as previously stated), so that on,-

July 13, under Chloroform, Laparotomy × was performed. The moment an opening was effected yellow - curdy - masses were discharged, which continued more-

× vide Treves, Surgical Applied Anatomy, Edit II p. 309.

or left throughout. On introducing the hand into the abdominal cavity, loculae were distinctly felt - their walls being formed by adhesions. The abdomen was washed out with boracic lotion, drainage tubes introduced, & the wound dressed with Iodoform Ointment & Styptic wool.

After Progress.

(I) The Diarrhoea was completely checked by the operation. The bowels were never opened (vide charts), until July 27, when, it was deemed advisable to give an Enema. This having acted freely, they were never again opened, until August 3, when a second Enema was given. After that, they moved, once or twice, naturally.

(II) The Temperature, it will be observed, first of all was normal - then, for a short time, shot up - & then gradually improved.

(III) The Condition of the belly. Every day, as stated, masses of yellow, cheesy or curdy material came away

so that it gradually decreased in bulk, until, finally, the walls, instead of being distended, became collapsed. The discharge caused great irritation on the surrounding skin - & (being deprived by illness of my supervision) there gave rise to bed sores which weakened him & exhausted him greatly. The wound itself grew smaller.

(iv) Pain. Previously, the child had complained but little, save of some epigastric tenderness, Even after the operation, he complained greatly of it wearying both patients & nurses by his constant cries which, however, usually yielded to morphia given in dose, rather large for his age

(v) General condition & Result, Except in the two points above indicated,

viz. Diarrhoea &
Temperature,

- in which there was marked improvement - this was never satisfactory. For awhile, he seemed to improve

somewhat, but this soon passed away, & he gradually grew weaker & weaker till on August 5th, he breathed his last.

I did my best to obtain a post. mortem examination but in vain. The people, in this town, are specially unwilling in this matter. One father remarked to me "he had been used to doctors, who knew, what was the matter, without looking". The parents of the present case made similar remarks, the father closing the discussion by remarking, "that as he had been 'opened' during life, it was quite sufficient & he would not permit him to be similarly treated after death.

Doubtless we should have found General tuberculosis & an abdomen whose Contents were matted together in almost inextricable Confusion.*

* vide Dr Woodhead's Practical Pathology, Edit II. p.p. 363 & 364 also Treves Surgical Anatomy p. 296.

Closing Remarks.

These would have been more valuable if (I)-as previously stated - I had not been kept by illness from noting the case more fully. (II) had I imagined that such a line of treatment would have been adopted, never having seen it before + having myself mainly trusted to dieting + drug treatment, I was not prepared for it. Certainly the boy wd have died if left alone, + the operation did not hasten his death. Once more it wd have had a better Chance if done earlier. I venture to think it will be long before Laparotomy for Peritonitis comes much into vogue unless it be for Seamen Hospital patients. Parents are so unwilling to consent + should it fail, as this did, adopt one of two Courses, they either say, the operation Killed him, or remark it wd have been Cruel to let him die in peace

Remarks on some of the commoner varieties of disordered primary or secondary dentition, as met with in the out patient department.

I Atonic Dyspepsia,
(including Atalusia)

II Chronic Gastritis or
(Inflammatory Dyspepsia)

III Hepatic Dyspepsia & Congestion,
(with special reference to the
dietary Suitable in such Cases)

For after little studied-while at college-is the important subject of — Dyspepsia. And yet, I cannot help thinking, in spite of Clifford Allbutt's dictum, that few complaints are more common. No one can be much in the out patient room of a hospital, without being struck by the great number of patients, in whom, a very careful examination reveals little more than that they have "pain," somewhere or other over the abdominal region. Now, it wd be comparatively easy to treat one & all by pumice, I am bound to say, in the treatment of some successful Borough Empirical practitioners. And, I am more & more convinced that, if a patients "pain" is cured, he cares for little else, totally unaware, as they are, that very serious pathological processes may go on without pain†. It is needless to say that such a practice as the above, persevered in, soon lands him who tries it in disgrace. And it is in the endeavour, to systematically class & treat the various kinds of dyspepsia & abdominal trouble, that I have ventured to write the following remarks. For without diagnosis, it

* Cf Sir Henry Thompson's Food & Feeding Edit III p. 6

† Habershon's Diseases of the Stomach 1879. p 41.

is impossible to treat; & this is specially true in the case of Gastric & intestinal Disorders.

Some Points to be considered in Diagnosis

1. History. We must, in these cases, depend much on the patients statements, for there are no marked "physical signs" in such functional disorders. He, alone, can tell us whether pain is felt before Eating, while Eating or some hours after as in duodenal dyspepsia*; & so forth in many points

* Habershon op. cit. p 208.

2. The Tongue. is as Milner Fothergill remarks "The only portion of the alimentary tract which admits of easy Scrutiny."* And of much of the rest of the alimentary tract, little is to be made, even when examined, post mortem, so Dr. Woodhead, — "It is, therefore, impossible to give an exact & non arbitrary account of either the naked Eye or Microscopic appearances in many Diseased Conditions"*

* Physiological Facts in Diagnosis p. 39.

* Woodheads Practical Pathology 2nd Edit. p 347

3rd Condition of the Renal Secretion

Dr. Fothergill is very inconsistent here. He advises a careful Exam[n] of a patients Stools*, & yet decides the Results of urinary testing. Much more correct is Dr.

Fothergill's Indigestion 1881. p. 131 ditto. Physiol. Facts in Diagnosis p. 133.

Charles Henry Ralfe, who remarks that, "there is no department of Clinical Medicine so perfunctorily performed at the bedside of urine." *

4. Condition of the Fæces, as well as the activity or sluggishness of this function

* Ralfe's Morbid Conditions of the Urine vide Preface also Ct Clinical Chemistry p. 104.

Finally there are a host of Symptoms Complained of by the patient (such as nausea, headache, pyrosis, cardialgia, flatulence) which need not detain us. Neither has the oesophagoscope * any practical bearing on dyspepsia

---

I. Atonic Dyspepsia.

Symptoms.

These, generally, begin gradually, often following an attack of gastritis. The patient complains more of general discomfort & of a sense of distension than of actual pain. He is troubled, most of all, shortly after eating, but seldom, if ever, vomits. Along with these symptoms, there is, often, great depression. There is no epigastric tenderness *. The tongue is "broad flabby, thinly covered with white fur, with its edges indented by the pressure of the teeth." * The bowels are Constipated

* Morell Mackenzie Diseases of Throat Vol II p. 15

* Fenwick's Medical Diagnosis 4th Edit. p. 165

* Ralfe's Morbid Urine p. 40.

the intestinal tract- showing in the feebleness of the stomach. The urine, in cases of this flatulent dyspepsia, has its natural acidity considerably decreased; it may be neutral or even alkaline, & in severe cases, a persistent deposit of oxalates, associated with peculiar traces of nervous depression, is generally met with." It gives a permanent blue to red litmus paper & effervesces on the addition of acetic or nitric acid, a condition due - Dr. Ralfe tells us - to excessive elimination of the carbonates of soda & potash or of the alkaline phosphates; of less than a dessp of both. He is often troubled with palpitations & his skin is dry, not a few cases, sallow & dry.

† Ralfe's Natural Urine p. 47 & 48.

also vide, Ralfe's Diseases of the Kidney p. 453 Key.

× Ralfe's Clinical - Chemistry p. 113.

Treatment

A. Prophylactic.

It is evidently essential to avoid & remove every possible Cause. Eg. hurried meals an indolent life, etc.

B. Dietetic

"The × food should be of such a nature as will require the least possible exertion, on the part of the stomach". Thus, "mutton is more easy of digestion than beef though this is not appreciable to a healthy person×. Veal, lamb & pork shd be avoided. Vegetables should for the

Tecani's Dictionary of Medicine p. 1525-

Parkes Treatise on Food & Dietetics 2nd Ed. p. 147

time be shunned. ×Tea, milk, Alcohol, should be sparingly indulged in. × Ralfe's Morbid Urine p. 44.

C. Medicinal

The object is,- to prevent decomposition of the organic matters of the food. The selection of the drug depends on the special features of each individual case, thus.-

I When the nervous system is greatly depressed; & there is no deficiency of the gastric juice, Dr Ralfe advises, (the urine being alkaline, neutral, or faintly acid), the exhibition of the Tr of nux vomica along with Dilute Hydrochloric Acid - Phosphoric - or Nitro Muriatic, as may be deemed most suitable×. × Ralfe's Morbid Urine p. 58.

He advises their administration, before meals, as given at that time, they brace up & "directly affect the vascular system"×. Dr Habershon endorses this treatment, remarking, "mineral acids are of great service, & assist digestion" × Quain's Dictionary of Medicine p. 1526. × Habershon's Diseases of the Stomach p. 131.

II When the Gastric Juice is deficient, Dr Ralfe advises the administration of an alkali, before food, along with a bitter. A similar combination is highly praised by Dr Milner Fothergill.× Handbook of Treatment p. 275

℞. Tr Nucis vomicae ♏ 10.
Pot. Bicarb gr XV.
Inf Calumbae ad ℥i

at this moment, several cases occur to my own mind, which were greatly benefited by this Combination. It is, very important, to give alkalies, before meals, when an increased secretion of Gastric Juice is desired; for as Dr Sidney Ringer[x] points out, if this is done we aid the function of the alkaline Saliva. For, it is desired in giving an alkali, before meals, to secure an effect on

(a) The amount of Gastric Juice,

(b) The urine.

and if given, before, it is absorbed uncompounded into the blood, causing an increased acidity of urine; whereas, if given during digestion, the urine is rendered more alkaline[x], the acid Contents of the Stomach decomposing the Salt. Certainly, as Sir H. Thompson insists[x] when urine is alkaline from local vesical conditions it cannot be altered by acids given by the mouth, but it is different in the Cases under Consideration, where the reaction is variable.[x]

Should these means fail in securing sufficient Gastric flow, the use of pepsin & an acid is advisable at mealtimes, though owing to its Expense

Ringer's Therapeutics 9th edit. p. 197 & 176

cf Ralfe's Morbid Urine pp 56 & 144.

Sir Henry Thompson's Diseases of the Urinary Organs. Edit VII p. 153.

[x] Ralfe's Clinical Chemistry a. p. 130.

I seldom give pepsin to hospital outpatients.
Benger's Liquor Peptonis is as good as any.
Vinum Pepsinae is not good[x]. (Of course,
an acid should never be given, before
food, if it is desired to increase the flow[x])

[x] vide Burbidge's Materia Medica. p. 81.
[x] vide Reynes Op. cit. p 181.

The Sulpho Carbolates are advised for
checking flatulence - so troublesome in
this complaint - Personally, I do not
much use them. They are best in Cases of
Sarcinae[x]

[x] Farquharson Therapeutics 1913. p. 172

The Constipation is best remedied by a pill
such as. Rx.

Pulv. Ipecacuanhae gr ½.
Ext. Cinchonae gr ½
Pil Aloes et Myrrhae gr iii

Dry Soil & dry Weather are much in
favour of Acne.

Dr Fenwick remarks, with his usual
sense, "Innumerable Remedies are rec-
ommended but in order, that they
shd be usefully Employed, the Cause,
of imperfect Secretion, must be
ascertained"[x].

[x] Quain's Dictionary of Medicine p. 1526.

Finally, let me say, that in this
Complaint, perhaps more than in any

other, much depends on the personal influence of the medical adviser, himself

Chronic Gastritis.

This, is stated by D. Jenwick,[x] to be the disease, most commonly met with in practice, hence he following remarks: for in this my intention, is describe only a few of the commonest varieties of "Dyspepsia", using the term in its widest sense.

[x] Quain's Dictionary of Medecine p. 1538.

Symptoms.

These vary, greatly, in degree. Here, "there is pain, increased shortly after food, & tenderness, on pressure, in the epigastrium" very different, in these two particulars, from Acute Dyspepsia. The tongue is coated & indented with the teeth or red at the tip & edges. If the liver be simultaneously congested, it is "coated with a thickened epithelium of a brown or yellow hue". Nausea is frequently complained of, but vomiting is not so frequent, as might be Expected[x]. Still, the stomach is very irritable. Three main Cardinal features are described by D. Habershon, which are usually present.

[x] Jenwick's Medical Diagnosis Edit. IV. p. 166.

[x] Quain's op. cit. p 1539.

(I) Tenderness, at the Scrobiculus cordis, (already referred to).

(II) irritability of the Stomach, often disproportionate to the pain. Thus in gastric ulcer the vomiting is preceded by pain - in inflammatory dyspepsia little complaint is made.

(III) a desire for cold drinks.

The bowels are generally confined, unless the catarrhal Condition of the Stomach has spread downwards.

The urine is high coloured, & urea is generally in excess; (This may be easily estimated by Squibb's process, with the U.S.P. solution of Chlorinated Soda; though a excellent work like Whitaker's does not mention it); & it deposits lithates freely.

Such are the main features: every patient complains of some special feature. Heartburn is very common.

× Habershon Diseases of the Stomach Edit. III p. 148.

× vide Ralfe's Treatise on Diseases of the Kidney. (H.K. Lewis) p. 73.

× Whittaker's Students' Primer on Urine p. 17 et seq.

× Quain op. cit. p. 633.

Treatment

A. Prophylactic.

As in every other complaint, the Cause must be treated & avoided, whether it be a dilated heart, Chronic renal disease, excess in food or alcoholic liquors.

B. dietetic. The diet should, above all things, be bland & nutritative[x]. Some of the combinations, advised by Dr. Fothergill, are useful[x]. Stimulants should be given up; & for the future, vegetables & fruit. Tea is objectionable, specially green tea[x]; Coffee, not always suitable, is better, having alterative action[x]. A Farinaceous diet is, at times, better borne than a restricted nitrogenous dietary.

Habershon op. cit. p. 156.

v. Fothergill's Food For The Invalid.

[x] Pavy's Dietetics p. 334. Diets p. 361

C. Medicinal.

Nothing is so good for the pain[x] as Bismuth, (given, if needful, with morphia). But, it is seldom given in sufficient doses. I am persuaded, by practical experience, that the time honoured dose of 5- 10 Grains of the Subnitrate is totally inadequate. A teaspoonful is a good dose. Many doctors blame drugs, when really they have never given them a fair trial. Take for instance, Belladonna, how few medical men are aware that children bear it, like rabbits[x]. I have known more than one hospital physician advise m v, for a dose, when m 60 would alone effect a cure. The tolerance of children to anæs-

Vide Bartholow's Therapeutics Edit. IV p. 134.

Farquharson's Therapeutics Edit. III p. 272.

is better known. The Bismuthis will
given with an alkali, (which, as Prof
Francis Stewart often said sleep one) is given
in smaller dose. For example.

℞ Bismuthi Subnitratis ℥ij. (-℥vi)
Sodae Bicarbonatis ℥ii (often ℥i is better).
Spir. Chloroformi ℥ij. (or 6ss) ×vide Extra Pharmacopoeia p. 259.
Mucilaginis Tragacanthae ×
vel Glycerini ℥ii
℥ Cardamomi Compositae ℥ss.
Aq ad ℥xii
m. ft. mist.

Sig
℥i ter in die.

Given before meals; if necessary, Liq Morphiae Hyd. can be added.
The above is really a justifiable "double barrel", & has often done me good service, though there is nothing special in it, save the doses.

Constipation must be avoided. often an occasional dose of Mercury is useful (℞ Pil. Hydrarg Cubebin Co.) followed up by Saline purgatives abundantly diluted with water. Where the patient is not robust, milder purgatives are called for. Such as, a combination of the 2 including of Physostigma - Belladonna (Squire's)

& Nux vomica[x]

Bartholow Op cit. p. 474.

Among other remedies, Arsenic[x] is highly praised given before meals, in minim doses, but I have no experience of it as Bismuth usually answers & my outpatients prefer pink pills!! a peculiarity of the ordinary lower class English patient.

dites p. 141 also Ct. Russell Therapeutics 9th edit. p. 308

Hepatic Dyspepsia

is, perhaps, a better term than the popular one of "bilious-ness," which last is, too frequently, used as a cloak for ignorance. The liver for anatomical reasons - (namely, that the gastric veins pass into the vena portae & thus directly to the liver), often shares in gastric trouble. An occasional attack is termed a "bilious attack", but, if the irritation be kept up, Hepatic Dyspepsia results.

Symptoms.

"The[x] tongue is, usually, furred, the fur being yellow or even brown, first thing in the morning; if persisting all day, worst then. Along with this, is experienced a bitter taste in the mouth" Sometimes, the detection of the altered colour requires very careful observation. The taste is due to taurocholic acid

[x] Fothergill's Indigestion & Biliousness 1881. p. 182

"The bowels are irregular, usually costive, & the evacuations are of a pale yellow-drab - or whitish colour & often of an offensive odour." *

Quain's Dictionary p. 840.

The urine is (often) scanty - loaded with lithates †.

Haberstroo Diseases of Stomach p. 160

Along with these features - ascertainable by personal examination - the patient has usually a long tale to tell. Everything is seen through a disturbed medium, & all the bodily functions suffer. He is depressed mentally complains often of headache - & alterations of vision. Disturbances of circulation are frequently present such as palpitations or sleeplessness *. The symptoms vary as they occur in a typically bilious person (in fair yellow skin & dark hair), or in persons, who live too freely. *

cf. Clouston Mental Diseases p. 69.

cf. Tuke p. 198.

Practitioner Hand Book of Treatment Tuke 1880 p. 402

Treatment.

A Dietetic.

This is most important, & most interesting Considering "liver disturbance" in its widest sense, there are certainly two distinct schools of dietetic teaching. I That very strongly insisted on by Sir Henry Thompson. Thus in writing of uric acid deposit- he says. "It used to be said that when uric acid is largely deposited, the nitrogenous elements of

Sir H. Thompson Lancet 2 Vols. VII p. 125

If the food shd be considerably diminished. I do not find that a strict application of this rule, in practice, suffices to attain our object. He goes on to say, that three articles of food are much more harmful, i alcohol;
ii saccharine matters;
iii fatty matters.
He does not argue the point, on its scientific basis, but states, that, Clinically, it is the correct treatment.

Other great surgeons hold similar views. This, if rightly understood it, was Dr Patrick Heron Watson's teaching.

II That insisted on, with equal vigour, by Dr Milner Fothergill, who again & again in all his writings & insists on the great evils of a nitrogenized diet in liver disturbance. For this view, he gives distinct physiological data, pointing out that one of the great hepatic functions is the oxidation of albuminous materials, & argues therefore, that a patient with a crippled liver should not have a nitrogenous diet. He further points out that a dietary of hydrocarbons does not overtax the liver, though it may

Cf. Fothergill & Bilton resp 1881. p 233

Cf. Pavy's Treatise on Food. Edit II p. 72

be, & indeed, frequently, is blamed, if both hydrocarbons & nitrogenous food be taken at the same meal. For, in such a case, "the more readily oxidisable hydrocarbons burnt first; leaving the less readily Combustible albuminoids, to be burnt as best may be" It is this residuum of nitrogenised material which produces the excess of bile, with the general disturbances produced therefrom. He points out how "the Gaucho has no hydro-carbonaceous food to prevent or obstruct the oxidation of the albuminoids though a flesh eater in a hot Climate does not suffer much from biliaries". Indeed to sum up, his view, briefly, is this that the "bilious" (under its widest sense) require the same dietary as the gouty.

* op. cit. p. 172

* 2 T. Kingsley Practitioners Handbook 1880. p 402

Finally, between two such opposite Schools, who shall decide? For my own part, I am inclined to follow Dr. T. Kingsley, & often do. Nevertheless it is an unpopular view, all the more so in a country like our own where meat eating is the order of the day, & in a century where the principles of abstinence have almost died out, being relegated to the limbo

, unless made with maize flour

of the so called "dark ages".
A dietary, something like the following, should be practised.

To avoid.

1. Lean of meat.
   specially beef,
   veal,
   mutton,
   lamb,
   pork,
   bacon,
   ham.
2. Eggs,
3. Cheese,
4. Pastry, (very indigestible);
5. Duck - Goose - Turkey.
6. Malt liquors.

To take.

1. fish, specially white fish, (avoiding salmon).
2. Fats,
3. Farinaceous Dishes;
4. Milk Puddings (without eggs)
5. Chicken sparingly.
6. Bread, toasted or stale
7. All vegetables,
   except tomatoes.
8. Weak claret & dilute fruit.
9. Fruits, guarding against any acid tendency, by using an alkali.

N.B. Rule of thumb is to be followed, for Each one has their own idiosyncrasy, in matters of digestion, & this is to be remembered as carefully as the fact that some patients cannot tolerate Morphia.

Cf. Dr. Parry Op. Cit p. 148

Exercise sho be systematically ~~taken~~; for, as Dr Pavy remarks,* "as long as free Exercise is taken & the circulation kept in an active state, favourable circumstances exist for the absorption of oxygen & the proper occurrence of metamorphosis & elimination". | *Pavy's Food & Dietetics Edit II p. 54!

B. Medicinal.

And here it may be well, to say a few words about some of the ~~salts~~ drugs, which do act on the liver

1. Soda & its salts do as much for the liver as ~~[illegible]~~ Bismuth does ~~[illegible]~~ for the gastro-intestinal tract. ~~It~~ is a good rule, soda for the liver, ammonia for the lungs, potash for the kidneys. Most of the mineral springs - like Carlsbad, Marienbad etc. owe their purgative properties to these salts. But outpatients cannot avail themselves of such places, & so I, usually, order them the following, —

℞. Sodae Sulphatis ʒi.
Sodae Tartaratae ʒß.
Tr Nucis vomicae ♏ xv.
Syrupi Zingiberis ʒii
Aq ad ℥i.

Many think soda sulphate is obsolete. I do not think so.

Sig. To be taken in a wineglassful of water, fasting, before breakfast.

2. Chloride of Ammonium. I confess, I think this a most valuable drug in Neuralgia*, but give it hardly ever to hepatic patients.

* Ringer's Therapeutics 8th Edit IX p 223

3. Mercury, Cannot be dispensed with, as Dr Ward remarks,* "notwithstanding the results of experiments upon animals, few practitioners will be content to give up the advantage which, their Clinical Experience has taught them, is to be derived from the judicious use of mercury." Certainly, it has been abused, but this forms no rational reason for its disuse. Again it should not be given (a) in fleet; for (as Dr Barkdow remarks) "repeated stimulation of the liver by mercurials can only result in the production of an altered bile." (b) in albuminuria. I quote from Professor Francis notes, "it is contra-indicated where the kidney is seriously out of order". A mercurial purge, at bedtime, followed, in the morning, by a Sulphate of Soda draught, constitutes a most satisfactory treatment. It will seldom fail when the tongue has its Epithelium bile tinged

* Francis's Dictionary p. 840

* Barkdow's Materia Medica Vol. IV p. 231.

Each practitioner will select his own preparation. As each noted accoucheur has his own forceps, or each Surgeon his own ideas of dressing, so every physician. ~~Habershon~~ advises a different one. Habershon advises the timed honoured Calomel or blue pill×. Morell McKenzie (though in a different class of cases), advises the Guaiac×. It matters little, provided the drug be used, when the occasion demands.

Habershon op. cit. p.162

Diseases of Throat. Vol I v. foot note p. 94.

4. American Eclectic Remedies such as Iridin – or still more popular – Euonymin – "Rutherford has shown that it is a highly efficient Cholagogue"×. Personally I find it very useful & give it after a formula to be found in Hart & Barbour's work.×

℞ Euonymin gr ii – gr iv
Pil. Aloes et Ferri gr v.

Bartholow op. cit. p.576.

× Hart & Barbour Gynecology p. 537

5. Aloes, Rhubarb, Taraxacum are at times useful. Aloes, not always, contra-indicated, if piles be present×.

vide Bartholow op cit p571 also Prof Grainger Stewart notes.

6 Mineral Remedies. –
are at times useful, though as Fothergill remarks, Alkalis are more

in favour as a rule Base acids" ×

Kirkpatrick Spec. p. 267

[Chalybeates are always Contraindicated where the liver is embarrassed.]

I need not continue the list to shall mention but one more drug.

7. Podophyllin. Sometimes very useful yet is at times uncertain. It acts best in Constipation. Many an outpatient gets the formula taught by Prof. Granville Stewart.

℞ Podophyllin Resinae gr ℈
Pulveris Rhei gr xxx
Extracti Hyoscyami gr xxiv.
M ft pil; divide in pil xii

or it may be given in the form of tincture

℞ Podophyllin gr ℈ ×
Essence of Peppermint ℥
Rect. Spirit to ℥

Extra Pharmac. p. 221

So much for medical treatment of hepatic disturbance. I close by remarking, that Satisfactory, as it often is, unless the dietetic suggestions be carried out, no treatment will succeed; unless indeed the patient eats to live, & does not live to eat.

Summary of Symptoms

	Atonic Dyspepsia	Chronic Gastritis	Hepatic Dyspepsia
1. Pain.	absent or slight, not aggravated by food.	severe, aggravated by food.	
2 Epigastric Tenderness	absent.	marked; but diffused & not limited to a special point.	"Tenderness at semicircular cord as follows". [1]
3. Bowels.	Constipated.	Confined usually, [2] ("sometimes irregular, if the catarrh has spread to the bowels they are loose.)	irregular, flew Confined. (Sometimes constipation alternates with looseness). The stools are pale. often very offensive.
4 Urine.	tends to alkalinity & in severe cases, deposits oxalates. [3]	"high coloured, deposeting lithates but, as attack subsides, may be alkaline or slightly acid".	dark coloured, turbid, loaded with lithates.
5 Principal Clinical Feature.	Flatulence.	Irritability of Stomach.	Bitter taste in the mouth.
6 Mental Condition.	worried & depressed.	Irritable.	more of a "melancholic" tendency.
7. Tongue	Large. Flabby, indented by teeth. Thinly covered by white fur.	Coated, flew injected at tip & edges.	furred, with a yellow or brown fur, Sometimes readily Cleared for its detection.

References
1. Habershon. op. cit. p 161
2 ditto - p. 153
3. Ralfe's Clinical Chemistry p 113
4 Quain Dict. of Med. p 1589.

	Atonic Dyspepsia	Chronic Gastritis	Hepatic Dyspepsia
8 Vomiting.	is extremely rare.	fairly common but is not preceded by pain.	a common symptom if *the stomach participate
9 Acidity & Heart Burn.	very rare.	very common.	not marked. rather is there languor & malaise
10. Dietetic Treatment	need not be very rigorous; but flatulent or very indigestible food is contraindicated.	<u>Bland Food</u>	Avoidance of Nitrogenous diet; (cf previous remarks)
11. Some of the most useful drugs, (in my own opinion, which I conceive is desired in a thesis)	Nux vomica. First of all acids (then alkalis if unsuccessful) <u>Cf remarks above</u> ×²	Subnitrate of Bismuth in large doses. Alkalis in less quantity	Mercurials occasionally. Soda salts (or mineral waters) systematically). Euonymin, if the mercury disagree.

*vide Haberson op cit p. 160.
×² cf Ringer's Therapeutics Edit IX p. 4.

Remarks on some of the commoner Eye diseases, with special reference to,

(a) Diagnostic Signs;
(b) Treatment.

I have destroyed these as, on final perusal, they seemed much too fragmentary & inaccurate.