

they are held back by civilization and will not get help unless it is carried to them. The majority of them never saw a railroad; are frightened when they see and hear an engine for the first time. But this is beginning to be a national menace; railroads are now going to these hotbeds of trachoma and the trachomatous patients are being brought to the cities. Lexington is the gateway to the mountains of eastern Kentucky, and until the Government service took charge of this work, I was seeing cases in increasing numbers every year. When I made my first trip I was amazed at what I saw and so would you be. It is the duty of the medical profession to teach the people to become interested in the eradication of this disease. It is increasing in central Kentucky. We find it in our city schools; we find it in the best families, and it is a reproach to ophthalmology, to the science of medicine, that the etiology of this disease has not been discovered. It is hard to get an audience that will listen to a lecture or to a description of this disease on the conservation of vision. We can do nothing unless we educate the people. We are sending \$10,000 a year across the sea to people who do not know our language, and yet we are not spending 10 cents to save true Americans, the real Anglo-Saxons of the race, in the mountains of eastern Kentucky and Virginia. The pain, the misery, the blindness, the suffering of these people is indescribable, and if Dr. McMullen and I were to tell you one-half of what we have seen with our eyes, and if these trained nurses could describe what they have seen, it would sound more like fiction than reality, and it is time for us to wake up and stamp it out as we have yellow fever and other diseases.

Dr. John A. Ferrell, New York, N. Y.—I wish to express my appreciation of the work of Dr. McMullen in ascertaining the prevalence of trachoma in this country and the excellent results he has obtained in bringing the disease under control. He is a real pioneer in the field of public health.

Trachoma has been found prevalent in a number of other countries, including particularly Egypt and Brazil, where public health measures have been undertaken for its relief and control. In this entire field the work of Dr. McMullen in this country and Dr. MacCallan in Egypt is unique.

While in Kentucky several months ago I visited one of Dr. McMullen's trachoma hospitals. It was a revelation to me to observe the large number of patients who had traveled many miles for treatment. The severity of the disease was quite striking. Many of the patients on entering the hospital could scarcely see and found it necessary constantly to protect their eyes from the light.

I am glad to have this opportunity to express my appreciation and commendation of the very valuable work that has been developed and directed by Dr. McMullen. It is to be hoped that his effective working methods may be adopted in other fields where the disease prevails.

I would like to move that a resolution be drafted commending the work of Dr. McMullen and urging the legislative bodies of this country

to give whatever additional aid may be necessary for its proper extension.

Seconded and carried unanimously.

Dr. McMullen (closing).—What Dr. Stucky has so ably stated about remedying the condition of a great many people who suffer from trachoma is true. The fact is that these regions in the Appalachians have recently come into prominence on account of coal mining and causing railroads to be built, as a result of which those people who live in the mountains find their way into other communities and they should not be permitted to carry with them this communicable disease. These people have a right to expect an equal chance with their neighbors, and this is denied them if they keep their trachoma.

The public health work which we are doing has some advantages in some respects, as the relief afforded is often remarkable. In this disease we sometimes get rather spectacular results in the way of cures, and when a patient returns home he advertises the work because he has been cured of his trachoma and his vision is markedly improved.

In making a talk some time ago on trachoma some one asked what we did with these old cicatricial cases, cured so far as active trachoma was concerned, but with pannus and all those things which we fear as a result. I promptly told him that we used them as boosters. With the proper entropion operation the pannus usually disappears as do the active corneal ulcerations, and vision is so much restored that the patient goes back home practically a new man, and that is what I mean by somewhat spectacular results.

I am glad that Dr. Goldberger made the point of additional funds for the prevalence of trachoma is far more extensive than we realize and the trachoma campaign should be extended. This is particularly true in regard to the field work.

In the routine school examination, if trachoma is diagnosed early and promptly, and properly treated, the child can usually return to school within two weeks. The average incipient case found in the schools is usually not difficult to cure, provided the proper surgical methods are used.

We have a number of doctors under treatment who have contracted trachoma in the Appalachians. One of our doctors who was in charge of one of the trachoma hospitals contracted the disease and has been obliged to discontinue active duty for a time.

## AUTHORS' ABSTRACTS

### Public Health

The Work of the Division of Sanitary Engineering of the West Virginia State Department of Health. Mayo Tolman, Chief Engineer, West Virginia State Department of Health, Charleston, W. Va. The West Virginia Medical Journal, January, 1917, p. 244.

Public health work should proceed along two lines, namely, (a) the reinforcement of the human organism in its struggle with disease-producing microbes, and (b) the exclusion of these microbes and their destruction in the environment. Some diseases, notably smallpox, may be

warded off by increasing the vital resistance of the human body, while other diseases, as typhoid, may be prevented by improving the physical surroundings of that body. As his training causes him to study communities at large, while the physician's viewpoint deals primarily with the individual, the sanitary engineer is best fitted to control those improvements that are instrumental in warding off disease.

Sanitary engineering embraces the design and construction of all works contributing to the public health, and all means of preventing offensive conditions due to large numbers of persons living in closely-built-up communities. It is the duty of the sanitary engineer to see that these public works are so constructed and operated that they are conducive to health and comfort. It quite frequently happens that sanitarians become so enthusiastic over bettering health conditions that they lose all sight of relative values, and do not balance the cost of benefits against their value.

Realizing this, the Division of Sanitary Engineering has at all times carefully weighed the benefits to be obtained from any proposed measure before urging it upon a community, and has endeavored to help towns solve their present health problems before forcing others upon them.

#### AUTHORS' ABSTRACTS

##### Medicine

(Continued from page 115)

On the Growth of Medical Knowledge Concerning the Malady Known as Infantile Paralysis, Acute Anterior Poliomyelitis, or the Heine-Medin Disease. Lewellys F. Barker, Baltimore, Md. The Charlotte Medical Journal, December, 1916, p. 257.

The paper deals with a brief historical account of the early descriptions of infantile paralysis by Heine and Charcot. The important contributions of Medin (1890) and of Wickmann (1905) are referred to, and the careful studies of the disease in recent epidemics in Europe and in this country briefly summarized. The etiology, epidemiology, prevention and treatment of the Heine-Medin disease are described in the light of knowledge as it exists at present.

Two Modern Methods to be Employed in the Treatment of Chronic Eczema. Chas. J. White, Boston, Mass. Journal of the American Medical Association, January 13, 1917, p. 81.

The investigations of the last three years have been carried on with the idea of throwing some light upon the vexed question of the etiology of eczema. The writer has been long impressed with the idea that there is some definite and possibly explicable cause for the susceptibility of certain individuals to external irritants, while others, be they infants or adults, when exposed to the same noxious influences, remain unaffected. Thus the work has been pursued upon the premise that eczema is produced by an external irritant working upon a sensitized skin. The question to be solved, therefore, was the nature of the occult sensitizing agent.

Following the lead of certain pediatricists, work was begun to prove or disprove the theory that food intoxications were the sensitizing agents in

man's susceptibility to eczema. For this purpose the so-called food tests were made on the healthy-appearing skin of many people afflicted with chronic disease. For the first year and one-half, raw foods, representing the various types of man's diet, were inoculated into superficial, clean scratches (a positive reaction being represented by the formation of a delicate pink papule about the seat of inoculation). For the last year and one-half, powdered proteins have been employed. The result has been to discredit the value of these latter agents; but the writer is convinced from his now somewhat extended experience with raw foods that a positive reaction to carbohydrate, to fat, or to protein should mean the partial or total elimination of the incriminated type of food from the patient's diet and that in certain individuals following such withdrawal there is an amelioration of symptoms hitherto unobtainable by previous drug treatment alone.

The second line of investigation has been microscopic examination of feces. It is not argued that stools, even of presumably normal individuals, may not reveal excesses of undigested fat, starch or protein; but these investigations have demonstrated that people with chronic eczema are very apt to show in their feces such an excess of starch or fat (apparently never of protein) and that following this clue and reducing or eliminating the type of food thus discovered, clinical results, previously impossible to achieve by external or internal medication alone, have ensued.

The Diagnosis of Gastric Ulcer. John W. Shuman, Sioux City, Iowa. The Journal of Laboratory and Clinical Medicine, December, 1916, p. 189.

Gastro-duodenal ulceration is to be only suspected if the subjective symptoms—hyperacidity, hunger-pain, food-ease and hypersecretion—are complained of. Physical examination must reveal a raw spot in the mucous membrane. This is found, if present, by the aid of a No. 14 braided-silk cord and lead ball, which is left in the stomach 6 to 12 hours. The relative size and location is interpreted by this test as well as the presence of an ulcer. The use of the duodenal tube is also described. For differential and confirmatory gastric technic the author lays much stress upon Roentgenology. Examination is made as the opaque meal passes into the stomach. Deformities are noticed, especially about the antrum and pylorus and first portion of the duodenum. The most important findings are deformities: (1) a diverticulum, (2) incisura, (3) a deformed cap (all must show constantly through a series of records, i. e., plates), (4) hyperperistalsis, and (5) a large six-hour residue are highly suggestive. And if in addition (1) is present, an ulcer is positive. If a deformed cap or duodenum is present constantly, the diagnosis is duodenal ulcer. Two cases are reported for comparative study in differential diagnosis. Both complained of "stomach trouble," and both had been, previously diagnosed as "gastric ulcer." One had an ulcer of the duodenum, the other had chronic appendicitis. The opaque meals are illustrated in the text. Shuman concludes that many diseases simulate gastric disease (ulcer) until a thorough examination is made.