logic condition, and was so, as, in a majority of cases, even prior to the inception of the specific zymotic poison.

When we are interrogated, why all children equally exposed to a certain contagion, do not contract the same? we answer that those who are not affected are in good habit of system; their blood is pure; they are in a healthy condition; by which expressions we mean to say, that the system is in a normal physiologic condition, and thus the poison finds no nidus of effete matter; in fact there is no soil for its propagation.

I recently had a case of scarlatina that illustrates the point in question.

A mother, 23 years of age, nursing her child, 20 months of age; the disease had manifested itself thirty-six hours prior to my first visit; tonsillitis severe, with much ulceration; eruption complete and fever high. Active elimination at once instituted through all the emunctories; commencing with a dose of castor oil, followed within one and one-half hours by a water enema, and as soon as a thorough evacuation was secured, a complete general scrubbing with soap and water, in a very warm room, was given. After patient was put to bed, her room and adjacent rooms were thoroughly aired, and throughout the course of the disease the air of the rooms was changed once an hour. We secured an evacuation of the bowels, and had surface of body sponged every twelve hours, as long as fever continued. The disease run a normal course. Patient recovered. The attendant was instructed to allow the child to continue to nurse the mother, and supply the deficiency by easily digested food. It was to have an evacuation of the bowels twice a day at least, and be sponged once a day. The child did not manifest even a symptom of disease. Prompt action as to elimination in case of the mother, was not only a large factor as means of cure to her, but in connection with the care given to child, secured immunity for it.

As it is true, that a system thoroughly cleansed of all effete and residual matter, foreign to a normal physiologic condition, is thus rendered less susceptible to, if not entirely exempt from, the disease in question; is it not the most rational procedure in treating the little patient, as early as possible, to eliminate through all the channels and maintain a normal action of the eliminative organs throughout the entire course of the disease, whatever else by way of medication is necessary to meet all the indications in the case?

I believe that early effective elimination is the most important treatment of all zymotic diseases, and if employed early is, in many cases an abortive means.

It is true that, in a large majority of cases we do not see our patient until the stage of incubation is past, and the disease has manifested itself by the signs peculiar to the specific pathogenic microbes. The genetic soil has been carefully, or rather, carelessly prepared on the part of the attendants; for certainly careless pernicious habits and especially as to ingesta, play an important rôle in preparing the fostering soil necessary to a rapid and copious generation of bacilli. This preparatory pathologic work, favoring the disease, but decidedly detrimental to the physician's success in curing his patient, this far, has been accomplished without any knowledge on the part of the doctor; and thus he is not responsible; but from thenceforward his responsibility is very apparent. And now the question which engages his careful attention is, Can I not, even at this stage of development, as it were, root up and destroy the growths and remove even their soil, by early effective elimination to the extent of modification, and thus

secure, at least, an unaggravated case of the specific disease, which will run within its normal limits to a happy termination?

There are degrees of severity in all so-called zymotic diseases, and why is *this* a severe, and *that* a mild case of scarlatina, if you please? Were not both patients equally exposed to the disease germs? We are sure that the difference in severity is not due to a difference in quality of the infectious matter. Is it then due to quantity? Not necessarily so. Both patients were exposed at the same time, and the same length of time. Then the difference in degrees of severity is not in the quality, neither in the quantity of the infectious virus; but is due to the peculiar susceptibility of the patient.

Idiosyncrasy has some bearing as a factor in the matter, but a vitiated, depraved system, due to poor elimination, does more toward the production of severe cases in all zymotic diseases, than any other cause. Now if it be true that poor elimination prior to inception, and thus a retention of effete matter, is the most potent cause of the severity in any disease of the class in question, then we rationally conclude, that if the system is clean, aseptic at incubation, and this condition maintained through entire course of disease, we will have a mild form and a very satisfactory result.

By early elimination, we mean, that there should be no delay in arousing the eliminatory organs, not to depletion, but to a full, free, normal activity. And if prophylaxis comes within the scope of this subject I would suggest that, during an epidemic, the physician and his patron advise with each other, so that the earliest indication of the disease be met, and this important preliminary treatment, as it were, commenced before the system reaches a high degree of fermentation.

I am aware that much more could be written on this subject with profit, and it is not within the province of this short fragmentary paper to discuss the therapy of this class of diseases; but brief as this is, if it will elicit a discussion more worthy of the subject, I am content.

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MENINGOCELE, WITH CASE.

Read in the Section on Diseases of Children, at the Forty-fourth Annual Meeting of the American Medical Association.

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The occurrence of pure meningocele is doubted by the most of our authorities. Conner says, (Keating's Cyclopedia of Diseases of Children): "If it occur at all, (and this is much doubted) it does so very rarely." Irving C. Rosse, (Reference Handbook of the Medical Sciences,) says: "The lesion is not yet sufficiently demonstrated to enable one to trace the symptoms, or even the diagnosis; on all sides it is admitted to be very rare, and some even doubt whether it exists."

I think it quite probable that the lesion is not quite so rare as the above quotations would indicate, because it is not an easy matter to certainly diagnose the condition even when present, and I have no doubt that in some instances, where no operation has been performed and no postmortem held, a diagnosis of hydrencephalocele has been made when meningocele really existed. In the case about to be narrated, the

lesion was supposed, up to the time of operation, to be hydrencephalocele. Before the days of aseptic surgery, the results of operation, in this unfortunate class of cases were so discouraging, so almost uniformly fatal, that very few surgeons had the temerity to attempt to do anything looking toward a radical cure.

I believe that with the resources at our command to-day, the prospect of success following the removal by the knife of these protrusions, is good; and as a reasonable basis for that belief present the following history of a case of pure meningocele:

The patient (female) was born on March 18, 1893, after an easy labor, weight six pounds. The mother was a primipara, and was in good health and spirits. Immediately after birth I discovered that there was a tumor in the occipital region about the size of a small hen's egg with a pedicle about one inch in diameter; the tumor was covered with apparently normal scalp, and was about as well supplied with hair as was the scalp proper. It was slightly reducible on firm and continued pressure, but the child became very uneasy when this was attempted. When the child cried the walls of the tumor became very tense, and the veins prominent. To the touch it seemed that the growth was divided indistinctly into two lobes of brain tissue surrounded by considerable quantities of liquid. Hence the diagnosis was hydrencephalocele. The anterior fontanelle was very large and the forehead abnormally high, indicating the presence of a moderate degree of hydrocephalus. The child nursed and slept well, but had gained nothing in weight, at the end of three weeks. At this time the tumor was perceptibly larger, measuring six and three-fourths inches in circumference. At the earnest solicitation of the parents, and after having explained to them the dangers of the operation, on April 13 I undertook the removal of the growth by excision.

Twenty-four hours previous to the operation the tumor and scalp in its vicinity were shaved, scrubbed with soap, and then with ether, and finally compresses of absorbent cotton wrung from a 1-4000 solution of corrosive sublimate were applied. Operation under chloroform anesthesia; a flap was dissected from the base of the tumor all around and reflected. An Esmarch's tourniquet was then tightly drawn about the pedicle, and the tumor excised as close to the tourniquet as possible. There was no perceptible effect on circulation or respiration, but the child's color was very bad, although this was noticed during the flap dissection, and before the tourniquet was tightened.

The contents of the tumor *were entirely liquid*. Not a vestige of anything resembling brain tissue was found. So that the diagnosis was necessarily changed from hydrencephalocele to meningocele. The sac was lined with extensions of dura mater and arachnoid. Nothing was found bearing any resemblance to pia mater. In spite of the tourniquet there was for a short time slight leakage of serum from within the skull, the opening in which would readily admit the end of my little finger. The tourniquet was allowed to remain under antiseptic dressings for twenty-four hours, when it was removed under chloroform anesthesia. Much to my disappointment, there was quite a flow of serum on its removal. I rapidly united the edges of the dura mater with continuous catgut suture and thus effectually stopped the leakage. As an additional safeguard a strong catgut ligature was thrown about

the remains of the pedicle above the sutures. The ordinary dressings were put on. The little patient was in good condition at end of operation, and has progressed steadily and favorably ever since. At this writing, May 29, the operation wound is entirely well, with only a slight thickening of the tissues to mark the site of the growth. The babe has gained three pounds in weight since the operation, a little more than six weeks.

Dec. 4, 1893. At this writing the patient is well, weighing about fourteen pounds. Only a small hard cicatrix remains to mark the site of operation. Mentally she seems about as well developed as the average child of her age.

SELECTIONS.

PATHOLOGY OF LARYNGEAL TUBERCULOSIS.

An Original Translation from the "Klinischer Atlas der Laryngologie u. Rhinologie," of Dr. JOHN SCHNITZLER of Vienna.

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The late Prof. Schnitzler, at the time of his death, was engaged in the publication of an Atlas of Laryngology and Rhinology, with explanatory text. This work presents the latest views, extant in German-speaking countries, concerning the pathology of laryngeal tuberculosis. The following translation, it is hoped, will be of value to the busy practitioner and specialist.

TUBERCULOSIS OF THE LARYNX.

Tuberculosis belongs to the most frequent and also gravest class of laryngeal diseases, consequently a clear understanding of it is of great importance, and on this account we desire to make this chapter as complete as the limits of the work will permit.

Etiology.—There can be no question that most of the changes observed in the course of laryngeal tuberculosis are due to an invasion by tubercle bacilli.

Furthermore, it is questionable whether many superficial ulcers in the larynx, occurring in the course of a simultaneous pulmonary tuberculosis, are dependent entirely upon the eroding action of the sputa passing over the parts, or upon the influence of pyogenic cocci in the sputa. This opinion can not be entirely ignored, since the rapid healing of many such superficial ulcers justly calls in question the tuberculous character of the same.

On the other hand, it can not be denied at the present day, that the swellings and ulcerations observed in the course of laryngeal tuberculosis are, in some measure, the result of a secondary infection. E. Fränkel, by means of culture media and stab-cultures, has established the frequent occurrence of staphylococcus pyogenes aureus or streptococcus pyogenes.

Likewise, Hajek has demonstrated the frequent existence of grape-like and chain-like cocci in tubercular ulcers. It is probable that the acute edema, which sometimes occurs in the course of tubercular destruction, may depend upon secondary infection.

Those perichondritic processes resulting from laryngeal tuberculosis, which can generally be ascribed to a secondary origin, will be mentioned later.

With our knowledge of the infective cause, the etiology of laryngeal tuberculosis is by no means exhausted, since the question of greatest importance is: in what manner does the bacillus of tubercle reach the laryngeal membrane?

This question, however, is so intimately connected with another, viz., whether laryngeal tuberculosis be a primary or a secondary disease, that the answering of the latter must precede the entire discussion.

The preponderating number of cases of laryngeal tuberculosis is associated with pulmonary tuberculosis. Gener-