DISCUSSION.

DR. A. C. COTTON, Chicago—I have listened to this paper with considerable interest, for I have had a limited experience with the thyroid extract, outside of the treatment of cretinism. I have had three adult cases on thyroids for the reduction of obesity. A more or less marked reduction of the obesity has been effected, but in two of them there has been an unpleasant symptom, i. e., headache. One patient could take 5 gr. of the thyroid extract three times a day, but when this dose was increased to 10 gr. three times a day she complained of headache, and I found no way of correcting that. I would like to ask Dr. Love whether he has observed headache following the administration of thyroid extract.

DR. I. N. LOVE, St. Louis, Mo.—I have had to regulate the dosage with both children and adults according to the effect, one of the disagreeable ones being, at first, headache. I have always observed some depression of the heart. This was why I was led to combine strychnin with the thyroid extract. I consider obesity in itself, in the adult, a misdirection, as it were, of metabolism. The nutritive processes are interrupted, and on general principles we should encourage elimination, activity of the circulation and all that will favor the establishment of the proper equilibrium of tissue building. In the ductless glands—of which the thyroid is one—we have important remedial agents. My experience also leads me to believe that the combination of strychnin with thyroid makes the treatment more favorable.

DR. G. M. BLECH, Chicago—Have you ever examined the thyroid gland in your patient before prescribing the thyroid extract?

DR. I. N. LOVE—I have not been able to observe very much apparent change in the thyroid gland. I do not believe the interruption of metabolism is always dependent on this gland. I feel like emphasizing the point made by one of our pelvic surgeons in America, in a paper read before the Mississippi Valley Medical Association—Dr. Sherwood-Dunn. He spoke of "The Conservation of the Ovary" and drew attention to the fact that it was related to the gland which had to do with tissue building. He argued that the ovary should be conserved to the fullest. I think our surgical friends—more particularly the younger men—should be warned against the needless emasculation of women. This point should be borne in mind in this connection.

SEPTIC CONDITIONS IN SOME OF THE ACUTE INFECTIOUS DISORDERS IN CHILDREN.*

BY A. C. COTTON, A.M., M.D.

CHICAGO.

It has been the custom of lecturers and writers to discuss disease by types, the nomenclature depending on certain groupings of symptoms and signs as indicating a particular disordered condition known as a disease. Within certain limits, variation in character, cause, duration, or sequence of symptoms was allowed without a change in name other than saying atypical. So also many well-known, and some rare, manifestations were observed and acknowledged under the terms, "complication," "sequelæ," etc., without, however, requiring a change in the established generic name of the disease. In the description of certain pathologic conditions the modifying terms, such as "acute," "subacute," "chronic," "retarded," "latent," etc., were employed to express at least the stage of the morbid process, though some of the conditions there described were so dissimilar that no relationship was discoverable save that of the name. In the acute infectious disorders, so loath have we been to surrender our nomenclature that great inconvenience and much confusion has obtained in clinical observation and discussions, the atypical prevailing much more frequently than the type, and the varying

complications presenting much graver conditions than the presumed original disease.

As a poor hypothesis is better than none, it is probable that our present nomenclature has served a useful end for the accumulation and classification of clinical data. As to persistency of type, probably no class of disorders presents so uniform grouping of symptoms as the exanthemata, yet the possible variety of complication and sequelæ renders the prognosis as uncertain as when dealing with some new and unknown disorder.

Thus far we have been obliged to accept such vague expressions as "climatologic influences," "epidemic characteristics," "individual idiosyncrasy," etc., in explanation of the widely differing results in these presumably familiar, acute infectious disorders. With the advent of bacteriology new light has dawned on infection, and etiology has become the guest of the home. That the advancement of bacteriology toward the claims of an exact science will soon compel sweeping revision, if not a complete overthrow, of our nomenclature, few will deny. Since clinical diphtheria is no longer a recognized entity, and Klebs-Loeffler diphtheria—pure and simple—a *rara avis*, the question may well be raised, why not discard a name which no longer carries any pathologic or etiologic significance? Since influenza without the bacilli of Pfeiffer is like the play of Hamlet without the melancholy Dane, why offend our sense with the persistent abuse of the term? For many years that revered term "pneumonia" has required so much propping up with adjectives that the careless tripper may bring down the entire pulmonary pathology about his ears. As went the ancient "dropsy," "jaundice," "biliousness," and "neuralgia," so must we bid adieu to the terms "influenza," "diphtheria," "pneumonia," and "rheumatism," or, if we retain these names at all, they must be so loaded with modification as to serve only as entertainment to the laity. The query, "what's in a name?" may well apply to our present classification when we consider our newer methods of clinical study, with their inexorable conclusions.

The effort to isolate the etiologic factor in morbid processes impels one to follow the chief mischief-maker, and whether we find him most active at start or finish, we keep him in view, regardless of the old clinical boundaries between inception, development, convalescence, recrudescence, complication or sequel. By persistence in ethical methods of study, we are at last beginning to recognize our real enemy among the factors of uncontrollable morbid processes. An antitoxin has been found that will do all that is claimed for it, viz., minimize the intoxication from pure Klebs-Loeffler bacilli, but that it will cure diphtheria as clinically recognized can not be maintained in the face of the still high rate of mortality. The apparent fact that clinical diphtheria was Klebs-Loeffler diphtheria and something else, had led to the most searching scrutiny as to what the something else was, and I believe no one will deny that the complicative factor which renders the intoxication uncontrollable is often due to the presence of the streptococcus. Whether we ascribe to this microbe additional toxic virulence of its own, or accept the hypothesis of symbiosis, the fact remains that in the graver forms of mischief he is present, and that intractable cases very rarely develop in his absence. So too in pneumonia, in pertussis, in measles, and above all in scarlatina and influenza, the intractable cases are rarely distinguished by the absence of the streptococcus. So evident has this become that the term "streptococcus" has frequently served in clinical description.

*Presented to the Section on Diseases of Children, at the Fiftieth Annual Meeting of the American Medical Association, held at Columbus, Ohio, June 6-9, 1899.

In this connection hasty revision of my case records for the past year inclines me quite strongly to the older theory of the "unity" of poisons in the etiology of acute infectious disorders. During the past season clinical influenza was quite prevalent in our city, and as seen by me, shows, among the severe cases, over 85 per cent. otitis media with streptococcic infection. Pneumonia of this variety of infection has been unusually prevalent among children, with over 75 per cent. of middle-ear infection. Pure Klebs-Loeffler diphtheria has been rarely seen, and was of a mild type. Scarlet fever, with membranous angina, with pneumonia, diphtheria, and with otitis media, has occurred in several cases, varying greatly in the intensity of the different complications, but showing uniformity in the presence of the streptococcus. An unusually large percentage of the relatively rare scarlatinal arthritis has appeared. And in violation of the general rule, Klebs-Loeffler diphtheria has, in a number of instances, accompanied the scarlatina from the onset, while the streptococcus has appeared sooner or later in nearly all. Pertussis and measles have shown unusual tendency to grave and persistent pulmonary complication, and the general tendency to extensive adenitis with an unusual number of suppurations marked by tardy recovery has been the rule.

It is to secure an expression from my associates in this Section, believing there is profit in comparison, that I present these few not well-classified observations, and I would like to ask the question: "Is this a streptococcus year?"

Treatment.—Since it appears, from the deductions of numerous competent observers, that it is the mixed infections that are the most intractable and fatal, whether by symbiotic action intensifying the toxicity of their products, or by the induction of fatal anemia by the prolonged demand for the antitoxin substance from the overworked blood-regenerating organs, it stands to reason and is apparently borne out in practice that three distinct lines of therapy must be followed in every infectious disease: 1. Prophylactic, as against the additional development of any other septic organism: All points of entrance, especially catarrhally-affected mucous areas, which under these conditions furnish rich culture-media for pathogenic micro-organisms innocuous under ordinary conditions must be carefully guarded by frequent application of local antiseptics. 2. Specific antitoxin treatment should be thoroughly employed, even when the presence of the specific toxin-producing microbe is not demonstrable, especially in infections that are favorable to others through some law of affinity not well known, and particularly during known prevalence of other infectious diseases, as in epidemics. 3. The application of the best-known principles of hygiene, with all the medical and dietary agents that go to promote healthful metabolism and powerfully reinforce the antitoxin-producing processes of the body, the great *vis medicatrix naturæ*:

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DISCUSSION.

DR. C. G. SLAGLE, Minneapolis, Minn.—All radical reforms, so far as I know, have met with more or less opposition, and in many instances, even with ridicule. This was the case even with the great discovery of Jenner. He was caricatured and denounced as a visionary, and some of the medical journals of the day even printed cartoons showing horns growing out of the heads of children, the supposed results of Jenner's ideas and practice. Professor Cotton is among the pioneers in a new field, which we older men appreciate. Bacteriology is opening up a new field which will materially aid us in that very intricate subject of diagnosis. In the end there is bound to be a revolution in medicine, but if you push it, as Professor

Rotch has endeavored to do; if you attempt to thrust these new ideas upon us all at once, the effort may result in failure, or at least it will retard progress. When I received Professor Rotch's book I was intending to lecture the next day on struma. I could not even find the word "struma" nor "scrofula" in the index, the appendix, in a foot-note or in a marginal reference. I did not find the word "dysentery." I looked further and did not find "croup," nor the word "colic." The familiar one, "diathesis," was not in the book. I addressed the author on this subject, and he replied very courteously that in dropping these old and unscientific terms he was only following out the suggestions of the American Pediatric Society. I remonstrated with him, and said that I did not believe that even such a master as he was could, by any one dash of his brush, obliterate all those old landmarks which had become as familiar as household words, not only with the laity but with physicians. You can not take any of the older books on medicine, and not find the words "scrofula," "struma," "dysentery," "diathesis," etc. It is all right enough to admit that these words are unscientific, and we must prepare for a revolution in medicine in the direction suggested in the paper of Dr. Cotton, but it will come better and faster if we do not push it too much. In medicine, as in literature, custom to some extent becomes law. These old medical terms must go in time; they are obsolescent now, and in due time will be obsolete. The paper is tremendously suggestive, and will bear discussion for a long time. The cause of the complication, otitis media, is something which we have just discussed. Streptococcus infection is quite prevalent now; it was probably so before, but was not recognized.

DR. G. M. BLECH, Chicago.—There are few papers left for this session, and I think, therefore, it would be well for Professor Cotton to favor us with his clinical notes, not to substantiate his claims, but as a matter of record. Concerning the difficulty of changing terms, as suggested by our friend, Dr. Slagle, this is an age of progress, and when we come to consider that certain terms have lost their value or meaning etymologically, they must go. There is no such thing as "scrofula"—there never was—and the only reason we used the term was because we did not know its pathology. We now know nothing but tuberculosis of the glands—"scrofulosis." The demonstration of the tubercle bacillus in the glands, or in the structures attacked is the plain justification of the omission of the word "scrofula." This term meant nothing; it gave only a very vague idea of a disease which was in reality nothing but tuberculosis. The same argument applies to the other terms referred to. They must all go since pathology has given us a definite idea of their nature.

DR. N. P. BARNES, Washington, D. C.—With all due respect to the statements of my friend, Dr. Blech, I have under my charge a large number of children in an out-door clinic, and I see many cases that may be tubercular, syphilitic, or rheumatic. These diseases seem to cross somewhere, or are so intimately associated that we can not say positively: "This is a case of tuberculosis." I do not like the word "scrofula," but there are conditions for which we can not substitute the term "tubercular lymphangitis."

DR. EDWIN ROSENTHAL, Philadelphia.—The last speaker is right. Not every case of lymphatic enlargement is tubercular, nor can we say that each case must have a certain name to indicate a disease. As to the late books, Holt gives "lymphatism" as the name of a disease and this can exist in those entirely free from such specific causes. I have met several cases of lymphatic disease that I am certain—and as certain as the bacteriologist is, who pronounces a cause—were neither syphilitic, scrofulous, strumous, nor tubercular, but simply depended on some condition as yet unknown. It is well to drop terms that give erroneous impressions, but we should do so at a slower pace, and when we do, we should have correct names to give.

I remember cases sent to the Municipal Hospital—the contagious disease hospital of Philadelphia—suffering from "glandular fever" (?). This was neither scarlet fever, nor diphtheria, nor tubercle, nor syphilis, and still it was thought best to send them to this hospital. The bubonic plague is another glandular disease that is not tubercular; and we can go on multiplying, in answer to Dr. Blech. This much we do know: when the term "scrofula" was used we knew that con-

sumption was the danger; its origin might have been syphilis or tubercle; the result was always the same and, hence this old name, which now appears useless, had its value in its time.

DR. G. M. BLECH.—Not every adenitis is tubercular any more than every vaginal discharge is gonorrheal in character. These things have been settled more than one year ago. The fact that certain glands are diseased does not prove that they are tuberculous. There are other forms of adenitis. I referred to that condition formerly commonly spoken of as "scrofulosis," and I assert that it is nothing more than tuberculosis. The use of these vague terms enables us to avoid making a correct diagnosis. By microscopic examination we are able to make a correct one of tuberculosis or syphilis, and then we can determine the particular form of adenitis with which we are dealing.

DR. N. P. BARNES.—We see hundreds of children with swollen glands about the neck. We can not at all times open these and examine them microscopically, nor are we justified in the measure when, under syrup of iodid of iron, these glands assume their normal dimensions.

DR. G. M. BLECH.—How long have you watched these cases?

DR. BARNES.—Some of them for 4½ years and I have never noted any cough or pulmonary symptoms during this time, that would be indicative of incipient phthisis.

DR. BLECH.—In all of these tubercular forms of adenitis there is usually an infiltration of the apices of the lungs, and by physical examination of the apices of the lungs, evidences of pulmonary consolidation can be discovered. A little of the gland can be withdrawn with a hypodermic needle, and the presence of the bacilli of tuberculosis demonstrated by microscopic examination.

DR. A. C. COTTON.—I confess that my sympathies run in the line of the views presented by Dr. Slagle. I make confession to what I consider an error on my part in teaching, i. e., using the old and indefinite terms because they are so convenient. I now believe that I have done my pupils injustice in this respect. The use of indefinite language leads to errors in thinking, and this will eventually crop out in the treatment of our patients. No matter how handy it may be to talk about diathesis and things of that kind, it is not right. I agree with Dr. Slagle that too sudden and sweeping changes are not advisable. We must remember, when we write and speak as teachers or as compilers of statistics or data, or when we make deductions for the whole medical profession, that we must not go over the heads of the mass of the profession. We must go slowly, yet we should always urge ourselves to the point of definiteness and accuracy, keeping as close to the etiology as possible.

Now, how many of you have struggled with a case of so-called diphtheria with a mixed infection and have finally had to surrender to the unknown, although you have worked faithfully, and have learned, perhaps a year later, that some one else has been called in because he cured some patient with diphtheria in the same block, at the time you lost yours. How heart-breaking that is. There is something more than pecuniary reward in the practice of medicine. It may be all right for you to tell some man that he will be well after he has taken your blue mass and salts, because he has an attack of "biliousness"—this is a term which most of us use—but when you touch on the acute intoxication, should you give our whole cause away by using terms which the laity think they understand? For our own protection, is it not worth our while to avoid using terms which the laity think they know all about? The pessimistic views of Dr. Blech are as refreshing as was the cool breeze last night. I am not so pessimistic; I can not make a diagnosis of tuberculosis as early as Dr. Blech thinks he can. He probably can, and I shall look to him to teach us all.

DR. BLECH.—I wish to call Professor Cotton's attention to a little remark much in vogue in my native country. *Am Ende hat Jedermann ein bisschen Tuberculose* (after all, everybody has a little tuberculosis).

"We are modifying our opinions about tabes and far more cases of this are amenable to treatment than has hitherto been believed."—James Nevins Hyde

CEREBRAL CYST: REPORT OF A CASE.

BY VAN BUREN KNOTT, M.D.

SIoux CITY, IOWA.

The object of this paper is simply to add to the evidence which is gradually accumulating in favor of operative interference in these cases, and to urge that those unfortunates so afflicted shall be given a chance for relief by surgery whenever the symptoms seem to make the localization of the tumor possible.

It must be admitted that brain surgery has not yielded the brilliant results which were confidently expected to follow in the wake of the more exact means of localization and improved operative technique. This has been especially true concerning the surgical treatment of intracranial tumors, for it is in just these cases where so much was expected and predicted that the results are as yet disappointing as a rule. However, in considering the application of surgery for the relief of these cases, we should not forget the point made by Ferrier, that we are dealing with a condition which, if allowed to progress without operative interference, is invariably fatal. From this point of view it would appear that the patient has everything to gain and little or nothing to lose from surgery properly applied.

The diagnosis and localization of the tumor are the essential points which must be settled before successful treatment can be instituted, and the most painstaking observation should be exercised that no sign or symptom which will assist in their determination shall be overlooked.

The case which I desire to report possesses no unusual features, but as this subject is one of great interest and practical importance I believe that all cases belonging to it should be reported, that a more definite policy concerning their management may be adopted. I have had some hesitancy about classifying this cyst under brain tumor proper, but Roswell Park says they are to be so classified when they involve the motor centers, as they then produce many of the symptoms of a tumor.

Eddie B., aged 14 years, entered the Samaritan Hospital in June, 1899. His father furnished the following history: About four years ago the boy fell out of a wagon, striking on his head. He was rendered unconscious by the fall and was carried into the house and placed in bed, regaining consciousness in about an hour. He remained in bed about three weeks, suffering considerably with dizziness, headache and inability to stand or walk. He gradually grew better until, at the end of four weeks, he was at play again as though nothing had happened. He continued in good health for about three years, when it was noticed that he was not walking properly: his right leg would drag, and he had a very noticeable limp. About this time it was noticed that his left eye was "crossed." Shortly after this he had a convulsion, which lasted only a few seconds and was not very severe. These attacks became more frequent and severe, until at the present time he has from six to eight in every twenty-four hours. From a bright, intelligent boy, he has become rather stupid and unobserving.

Present Condition.—He looks like a stout, healthy boy, well-nourished and of good color. There is complete paralysis of the external rectus of the left eye, with marked, left convergent strabismus. There is no impairment of visual power of either eye; no choked disc, nor optic neuritis. As he walks across the floor he drags his right foot, and examination reveals that he has practically no control of the extensors of the leg: knee-jerk is present, but very weak. The grasp of the right hand is about one-half as firm as that of the left,