

cardio-vascular group it is important to note the depression and fears which are exaggerations of the usual features of these maladies. Gastro-intestinal cases are similarly affected. The great excess of the female sex under the heading of generative disorders is in accordance with general experience. I have not been able to corroborate certain American observations which record extraordinarily voluminous morbid details in the sphere of gynaecology. There can be no doubt that the urine and vaginal discharges of the insane are highly toxic, but the vast array of surgical necessities alluded to is not within my experience, either by the bedside or in the post-mortem room.

The common concomitant of generative disorder is the irregularity or suppression of the catamenia. It is usually said that menstrual periods are accompanied by exacerbation of insanity. That is by no means the rule according to my observations. No doubt the return of catamenia is a favourable indication and we have had several such cases after the exhibition of ergoapiol where other drugs had failed. I might also record a case of recovery in which the catamenia continued suppressed and were restored by the introduction of a stem pessary at home. Quite exceptionally, I have had good results from the use of ovarian extract after ovariectomy, but can present no case under asylum treatment in which that preparation altered the mental condition. It is our routine practice to record daily on calendars the excitement or depression noticeable in individual patients. These calendars also show the days of menstruation. I have condensed these observations for years together, and on examination of the results find that it is quite exceptional to correlate the catamenia with the exacerbations of insanity; occasionally this is discovered in mania but never in melancholia, so far as my observations go. What is of much more importance are the toxic conditions of these tracts—whether puerperal or not.

My aim has been to direct attention to somatic disorders and to correlate those with insanity under two broad divisions—ordinary and pathological. Yet it is necessary to say something in general terms. For instance, the primary fact of consciousness has a relation to prognosis; if it is lost for any considerable space of time it is a measure of mental degradation indicating incorrigible defect. Mere confusion is not at all a hopeless condition, but delirium is of the gravest import. I have not found that perversions of identity are so incurable as was formerly supposed; but as a general rule it may be stated that perversions relative to self are much less intractable than those relative to others. Did time permit, these opinions could be supported by clinical illustrations, but I must pass to the sphere of sensation. The general *cœnasthenia* is of importance in this connexion. It is a common measure of convalescence to observe carefully the mental attitude relative to fatigue. A loss of the sense of fatigue, an abolition of sensation in regard to fatigue, denotes an uninterrupted course of mental disorder; on the contrary, when the patient begins to complain of fatigue and pain and discomfort the complaint is welcomed as the first sign of improvement.

The sensations colour the delusions, and in that respect the study of Table XVI. is interesting. The genesis of delusions from the painful sensations of gastro-intestinal disease is readily understood—it is easy to pass from the feelings of gastritis to the feelings of poisoning. In fact, I would venture on the generalisation that perverted sensations determine the tone of the delusions and the general mental condition. It is unthinkable that the depressing nature of abdominal disease, altogether apart from insanity, should issue in grandiose ideas or pleasurable excitement. It would seem that hallucinations can be an affair of auto-suggestion in some cases. The measure of degradation may be ascertained by observation of the power of attention and memory, yet these may be acute and the condition of the patient may be hopeless as regards recovery. It is commonly supposed that an unimpaired memory is an indication of sanity, yet the idiot *savant* may have a memory of extraordinary tenacity. The perversion of intellect may be complete and both attention and memory perfectly unimpaired.

In point of time, we have already seen that recent cases are most favourable in expectation of recovery and that cyclic variations are common; also that a sudden onset and a sudden recovery almost inevitably mean neuropathic inheritance and recurrence sooner or later. A settled periodicity is bad, yet if there are no remissions tending to recovery the outlook is not less gloomy. The best sign in this respect is intervals of remission, daily becoming of

longer duration; and it is specially gratifying when self-knowledge returns, interest in surroundings is displayed, and neatness of dress is studied—in fact when there is an indication of an appreciation of the amenities of existence, when the prayer of the Kilbarchan weaver is answered—in moderation.

And so we inevitably come back to the initial stage of this discussion, the importance of somatic conditions in relation to the mental states. Prognosis in insanity must proceed upon a wide and careful review of the whole circumstances affecting the individual, who is in a degenerative condition physically and therefore mentally. All that goes to make up that degenerative condition must be separately investigated and summed up. The elements of prognosis are analytical and synthetical, and it is determined by the nature of the degree of the involvement of the organism in the widest sense. If all the functions are involved, if the degenerative process is universal and intractable, the future of the individual is desperate indeed; if the defect is partial and amenable to treatment naturally the case is more hopeful as these limitations of involvement decrease. In that sense how hopeless is the case of pernicious *anæmia* in which the mental manifestations are the direct result of an impoverished brain. For a time it may be possible to draw upon the reserve of red blood corpuscles but the stock is not inexhaustible. It is in consonance with these observations that the toxic theory of insanity demands our most serious attention and excites our liveliest hopes. Prognosis can never be an affair of aphorisms; these *obiter dicta* require to be fitted into the general scheme of things; they are altogether too facile and too partial for our purposes.

Finally, on the general question of prognosis of insanity, we have been counselled to give a guarded opinion, because it is the unexpected that happens. An eminent physician once said that he was paid for an opinion, not for a prophecy. But an opinion is truncated and ineffective if it be only relative to the moment of delivery. The questions demanded of us are urgent and necessary: Is the family business to be wound up, are the pressing difficulties permanent or temporary, is the home life to be altered for a time or for ever, are careful plans for a career to be abandoned or postponed? I am impatient with a science that executes a strategic retreat before such a battery of questions. In the last resort, the kindly words of Horace recur to us:

“Tu ne quaesieris, scire nefas, quem mihi, quem tibi
Finem di dederint, Leuconce, nec Babylonios
Temptaris numeros.”

Yet it is a poor account of scientific medicine if it is to be recorded of us that our premonitions are of no more value than a Chaldean horoscope.

It is an excellent practice in which, throughout the years I have followed Sir James Crichton-Browne, to sum up the probabilities in the case-book on the reception of every patient. At least, it is a stimulating corrective for self-satisfied science; at best, an incentive to the careful study of every circumstance affecting each patient. For it is only by that study, indefatigable and personal, that advance is possible to us or to our profession. More steadfastly than ever our profession labours for the prevention of disease. That resolves in questions of eugenics, education in the widest sense, and a determined, informed study of all morbid phenomena.

THE MEDICAL TREATMENT OF CONGENITAL PYLORIC STENOSIS.¹

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THE symptoms and diagnosis of congenital pyloric stenosis are now well known and have been very fully described by Thomson, Cautley, Still, and others. The exact pathology of the affection is still unsettled and it may be that the results of treatment will throw fresh light on the subject. This paper deals only with the medical treatment by means of dieting and gastric lavage, a method of treatment to which Still has specially directed attention.² I propose to give brief notes of the last three cases which have come under my

¹ A paper read before the Clinical Society of London on March 8th, 1906.

² THE LANCET, March 11th, 1905, p. 632.

care and then to make some observations on the treatment generally.

CASE 1.—A male infant, six weeks old, a first child, was sent to me on May 22nd, 1906. The history was that the child had appeared to be healthy at birth but that vomiting occurred during the first week and had continued ever since. The vomiting was intermittent, sometimes only once a day, sometimes oftener, and usually occurred about 20 minutes after a feed. The vomited material was sometimes in large quantity and was violently pumped out. The child was losing weight steadily; the bowels were very constipated and acted only after the use of a glycerine suppository. The motions were small but healthy in appearance. The child was subject to flatulence, attacks of abdominal pain, and screaming attacks. He was always hungry and always ready for a feed. The diet had been the mother's milk and occasionally Allenburys food and peptonised milk had been tried and had been rejected. The breast milk when examined was found to be satisfactory, although the chief constituents were rather small in amount (proteids, 1.75 per cent.; fat, 2.4 per cent.; and sugar, 5.06 per cent.). The patient was a wasted, whining, unhappy looking infant weighing 7 pounds 6 ounces. On examination of the abdomen, after manipulation, the stomach was seen to be contracting strongly and peristaltic waves passed from the left to the right side of the abdomen. The pylorus was not felt. On the same night general convulsions supervened and lasted intermittently for 36 hours but passed off under the use of bromide and chloral rectal injections. The treatment ordered for the pyloric trouble was lavage once a day and a continuance of the breast feeding every two hours by day and every four hours at night, ten minutes at a time. On washing out the stomach a considerable amount of soft flocculent curd was removed, but this seemed to be of such a fine character that gastric digestion was evidently good. It was also considered that such a residue should pass easily through the pylorus unless abnormal spasm was present. The child remained under observation for three weeks during which the progress of the case was as follows. The lavage was carried out every day for the most part, sometimes every second day. The amount of residual food left in the stomach was found steadily to diminish. The vomiting became much less frequent and less violent, and towards the end of the time was trifling. The bowels came to act naturally without injections, and at times diarrhoea with green stools occurred. The employment of malt and oil, half a drachm thrice daily, seemed to produce gastro-intestinal disturbance. The child became much more comfortable and brighter with the cessation of the abdominal pain and vomiting. The weight at the end of three weeks was exactly the same as at the beginning. The infant then passed from my care and was treated on the same lines by a medical friend for a few weeks. Four and a half months later the following report was very kindly sent me by the practitioner under whose care the child had been placed. Steady improvement had taken place, interrupted only by a series of convulsions, which had been traced to the fact that the mother was menstruating at the time. The gain in weight was very slow but the infant now weighed ten pounds—i.e., almost three pounds heavier than when first seen. The weaning process was being carried out as the mother's milk was failing. The visible peristalsis of the stomach had passed off entirely two months previously.

CASE 2.—A male infant, three months old, was sent to me on Oct. 12th, 1906. He was healthy at birth, weighing 7½ pounds, and had been fed on cows' milk and water, which seemed to agree with him. At the age of five weeks vomiting had commenced and had persisted. It occurred once or more daily and was frequently very violent, the food being pumped out in large quantity. The bowels had been rather loose at first but later constipation had been marked, and for a month previous to my seeing the child the bowels had acted only after a glycerine suppository and the motions had been extremely small. The child slept badly, had frequent attacks of abdominal pain, and was always ravenously hungry. There had been a steady loss of weight going on for about two months. Many diets had been tried, including cows' milk and water, Mellin's food, peptonised milk, lacto, whey, and Allenburys food, but none of these had had more than a temporary effect on the vomiting. The child had been fed quite regularly every two and a half hours by day and somewhat less frequently by night. On examination the infant was found to be extremely emaciated and restless; he was whining, and he looked a picture of misery. His weight

was then 6 pounds 13 ounces. The temperature was normal. There was no sign of disease anywhere apart from the stomach. The abdomen was somewhat distended and gastric peristalsis was elicited by rubbing the abdominal wall. The contraction waves were very strong and passed right across from under the ribs on the left side to be lost on the right side of the abdomen. They were not apparently painful. The pylorus was not felt by me, but my friend Dr. Edmund Cantley, who kindly saw the case with me, was able to palpate it. As the infant was at the time on Allenburys food that diet was continued, and washing out of the stomach was performed daily. The vomiting rapidly diminished but complete digestion as ascertained by the results of washing out was not obtained until the feeding was employed every hour by day and every two hours by night. The bowels soon began to act naturally and a steadily increasing amount of faecal matter was present in the stools. The gain in weight was at first very slow and some weeks showed a loss of weight. The diet was varied with whey, peptonised milk, and cream, and a small quantity of malt extract, raw meat juice, and grape juice was given. The improvement was steady if slow and there was a definite change for the better in the infant's comfort and general appearance. The progress was interfered with at times by attacks of diarrhoea and later by an attack of influenza with bronchitis. The patient passed out of my care at the end of three months and was then a smiling active infant, keenly interested in all that went on, and weighed 9 pounds 6 ounces, a gain of two and a half pounds. The gastric lavage was still being carried out every second day as the influenza had left the infant very liable to gastric disturbance. Had it not been for this complication the washing out would probably not have been required so frequently.

CASE 3.—A male infant, three months old, was admitted to hospital on April 20th, 1906, suffering from marasmus. The child had been healthy at birth, but vomiting had come on a fortnight later and had continued. The diet had consisted entirely of the breast milk but wasting had been persistent. The bowels were constipated, acting only every second day, and there had never been diarrhoea. There was nothing of importance in the family history and the patient had presented no signs of constitutional disease. On admission the infant was found to be a typical example of "marasmus," very wasted, whining, always hungry, and sucking his fist. The rectal temperature night and morning was 96° F. The weight was six pounds. On physical examination the abdomen was found to be rather distended and tense and an inguinal hernia was present, but there were no signs of organic disease. A diet of equal parts of cows' milk, barley water, and lime water, half an ounce of each, was ordered, the feeding to be every two hours by day (16 hours) and every four hours by night (eight hours). At the end of 24 hours the quantity at a feed was raised to three ounces. After three days half a drachm of cream was given thrice daily. Under this treatment the child seemed to improve, gained six ounces in weight in ten days, and seemed more comfortable. The amount of cream was then increased to half a drachm at each feed and this was quickly followed by vomiting. On returning to the former amount of cream the vomiting ceased. On May 9th it was noted that although the bowels only acted once a day and enemata were sometimes required, the motions were satisfactory. The infant, however, was losing weight, although without any obvious discomfort or vomiting. Three-ounce feeds of milk and lime water, equal parts, every two hours by day and every four hours by night, with half a drachm of cream and 15 drops of cod-liver oil thrice daily were ordered. Vomiting quickly followed and continued. On the 14th examination of the abdomen showed marked peristalsis of the stomach in waves passing from left to right and a diagnosis of congenital hypertrophy of the pylorus was made. Washing out the stomach daily was ordered. The food was now changed to peptonised milk and water and later cream, whey, plasmon, and plain milk-and-water were given at times. The amounts varied from three to four ounces at intervals of three or four hours. The washing out was continued daily and there soon came to be but a small residue present in the stomach two hours after a feed. When, however, it was reduced to every second day a considerable amount of food was found and the daily routine was resumed. The vomiting was entirely relieved and occurred very rarely and in a very mild form. At the end of three months' treatment the weight was 6 pounds 11 ounces, a gain of only 11 ounces. The peristalsis of the stomach after a

feed was as marked as ever. The temperature ranged between 96° and 97°. Treatment by opium had been given a full trial, up to seven minims of liquor opii sedativus daily, without the slightest effect. After consultation operative treatment was decided on. The operation of stretching the pylorus was performed by one of my colleagues on July 28th. A typical large, hard, contracted pylorus was found. The only point about the operation which calls for notice is that the peritoneum was ruptured at the duodenal end of the pylorus and was sutured. The infant suffered from a good deal of shock during the following few hours but improved after saline infusions. Rectal feeding was employed for 12 hours and then one drachm of whey in an ounce of hot water was given every three hours. The amount of whey was steadily increased. On August 1st it was noted that there had been no vomiting for three days; the child was taking food well and seemed comfortable. The addition of malt or cream induced vomiting and whey alone was given. On the 3rd the child did not take food so well and he died suddenly and unexpectedly on the same night. At the necropsy the abdominal conditions were found to be healthy, there was no peritonitis, and there was no apparent cause of death. This sudden and unexplained death in marasmic infants after a serious operation is, of course, of common occurrence. The question as to whether better methods of feeding and other food materials might not have led to a cure of the pyloric condition without operation must remain unsettled, but further experience has led me to believe that the treatment might have been improved upon.

Remarks on treatment.—I shall not refer to the surgical treatment of this affection, a subject which was very thoroughly considered at the Toronto meeting of the British Medical Association.³ My hope and belief are that as our knowledge and experience of the medical treatment advance there will be fewer and fewer cases in which surgical intervention is called for.

1. *The objects aimed at.*—The aim of the medical treatment is to remove any source of irritation in the stomach which may maintain pyloric spasm and to keep the stomach free from any irritating food material, digested or undigested, which may excite pyloric spasm. Within recent years many cases of this affection have been seen in the post-mortem room, and as we looked at the hard hypertrophied tissue and the complete stenosis it was a common remark that only operative treatment could have relieved the condition. It must be remembered, however, that the pylorus has two functions, contraction and relaxation, and the fact that the muscular tissues generally are hypertrophied is no reason for assuming that only the power of contraction is retained. I believe that both these functions are present at birth and that there is in addition a congenital hyperplasia of the muscular tissues of the pylorus, as Cautley has so strongly insisted on. For a varying length of time, days or weeks in different cases, all goes well and the pylorus acts normally. But a time comes, even in the most carefully fed cases, when some irritating (undigested) food lies in the stomach and the pylorus contracts strongly and remains closed. Vomiting follows. The repetition of such a condition gradually induces a more or less continuous spasm of the pylorus, or at least a spasmodic contraction which seriously interferes with the normal emptying of the stomach. It may be that in some cases, as in those recorded by Willoughby Gardner, and Still, it is possible solely by careful dieting and the use of a food leaving little residue in the stomach to check this over-action of the circular fibres of the pylorus. Such cases are probably rare but they support the view that there is no inherent vice in the pylorus. They are rare because a diagnosis could seldom be made at a stage when such treatment would usually be effective. By the time a diagnosis can be made with certainty the spasm of the pylorus is established and as the result hypertrophy and dilatation of the stomach have followed. We have then to deal with a fastidious, irritable, dog-in-the-manger pylorus, which must be humoured and soothed and deferred to in every way. It is not to be supposed that even in marked cases the pylorus never relaxes. At operations it has frequently been found that the hypertrophied pylorus can and does relax and will often admit the little finger without difficulty. In many cases the presence of faecal matter in the stools and the absence of vomiting for a week or more show that food is passing through the pylorus. The gravity of the affection lies in the fact that it does not do so

in sufficient quantity for the nutrition of the infant. These would appear to be the grounds on which medical treatment may be expected to do good and, expressed in other words, the aim of the treatment is to restore the function of relaxation of the pylorus which has been in abeyance owing to the more powerful action of the constrictor muscular fibres.

2. *The food and feeding.*—Although the stomach is much dilated and is capable of holding a large amount of food, small feeds are called for in order to secure complete digestion. Two or three ounces will be found sufficient at a meal and in bad cases one-ounce feeds are advisable. In order to supply a sufficient amount of nourishment the number of meals must be increased. An infant, aged one month, should be fed every two hours day and night and in bad cases, when only small quantities are allowed at a time, every hour by day. This may have to be carried on for some months unaltered but if the progress of the case allows of it one will naturally try to increase the amount at a meal and feed less often as time goes on. If the infant will sleep for longer intervals at night he should be allowed to do so but hunger will usually awake him with great regularity. Small quantities, from one drachm to four drachms, of plain water or dill water or cinnamon water may be given between the feeding times if the child is thirsty or wakeful. The difficulty in the complete digestion of the food in the stomach lies in the proteids and the fats, more especially the latter. Over and over again I have found the addition of cream or cod-liver oil bring on gastric irritation and vomiting.

If good breast milk is available it is the best food. A chemical analysis of the milk should be made and one would prefer to have rather a low amount of all the chief solids. The fat should not be more than 3 per cent. The quantity given at a time must be regulated by the duration of the feed, five or ten minutes as the case may be. Unfortunately, in many of these cases one finds that suckling has been stopped in the belief that the milk was disagreeing with the child and one of the most useful adjuncts in the treatment is lost.

If artificial feeding is employed, cows' milk as usually modified does not act well owing to the heavy curds which remain in the stomach. The foods which have proved most successful in my experience are peptonised cows' milk (without added cream), whey, and Allenburys food (No. 1). This last I take as a type of foods which are not in themselves suitable for healthy children, but which are capable of very complete digestion in the stomach. In addition, malt extract, raw meat juice, and grape juice have been given daily in small quantities. No doubt other foods may be found equally efficacious and the question of the suitability of the food is to be decided by the state of the stomach contents after washing out.

3. *Gastric lavage.*—The stomach should be washed out once a day for a prolonged period, and in bad cases this proceeding may be required twice daily for a time. It is quite a simple process in young infants, and if properly carried out leads to no discomfort or disturbance. It should be done when under normal conditions the stomach is empty—i.e., two, or two and a half hours after a meal, as the case may be. The value of the information gained from the nature of the stomach contents cannot be over-estimated. The wash-out should show a small amount of soft flocculent matter, which tends to get less in successful cases as time goes on. If, on the other hand, a large amount of matter is washed out, or undigested curds, it is clear that the food is not properly digested and will maintain the pyloric spasm. Dr. Cautley has pointed out that in many cases the mere washing out of the stomach systematically will check the vomiting and that this may prove misleading. This is perfectly true, and therefore one must examine carefully the nature of the stomach contents in order to see whether the residue would be likely to pass the pylorus. If this residue is of the soft flocculent nature described above one may reasonably expect that it can, and will, prove non-irritating, and will eventually pass naturally through the pylorus. Other indications of improvement must also be looked for and will be referred to later. For the observation of these points and for the lavage to be of any real value it is of the first importance that the physician should carry out the proceeding himself and not entrust it to any nurse however skilled and experienced she may be. Gastric lavage is not only beneficial to the infant but is also the means of showing the physician how to regulate successfully the food and feeding.

³ Brit. Med. Jour., vol. ii., 1906, p. 939.

4. *Signs of progress*.—1. The vomiting ceases. This usually follows quickly after lavage and suitable feeding have been carried out. 2. The bowels act naturally. This is a very important sign of progress, for it is in such marked contrast to what occurs in untreated cases. In the latter constipation is the rule, artificial aids per rectum being very often required, and the motions contain little faecal matter. After the medical treatment has been begun the bowels act two or three times a day without artificial stimulation and the motions are larger and consist of faecal matter. 3. The stomach peristalsis becomes less marked, less strong, and gradually passes off. The complete disappearance of peristalsis may take some weeks or months, but the lessening is usually seen early in successful cases. 4. The discomfort, pain, apathy, and constant whining of the infant are removed and are replaced by a placid and comfortable state, in which even smiling is gradually evolved. 5. The nutrition of the infant is improved. This is manifested in a healthier colour, in increased activity of the limbs, and in a slow gain in weight. It is very important to remember that these infants cannot be fattened rapidly, that any attempt to secure this will probably end in disaster, and that the less weighing there is the better, especially if there are anxious relatives about. The most suitable foods are not fattening ones, and any excess of food is apt to produce disturbance either in the stomach or the bowel. On the other hand, the vital powers of the infant can be very much improved, and the disordered functions restored to healthy action, by a simple diet, and the fattening materials can be reserved to a later period. Progress in the infant is usually marked by a slow increase in weight, somewhat fluctuating at first, but tending to become steady as time goes on.

5. *Complications*.—A common complication in the course of treatment is diarrhoea. The bowel in such cases has been out of use for some time and is consequently unprepared for the food material which now passes through the pylorus. Hence probably arises an irritative form of diarrhoea. The best treatment is to reduce the amount of food given by one half and to keep it so until the diarrhoea has ceased. At the same time half a grain of grey powder may be given twice or thrice daily. When the diarrhoea ceases the amount of food can be again gradually increased. Such diarrhoea is always serious and may prove fatal. When vomiting occurs no food should be given for two hours in order to rest the stomach. Sips of hot water may be given if the child is thirsty. Intestinal flatulence is to be treated, like diarrhoea, by a temporary reduction in the amount of food.

6. *Medicinal treatment*.—The use of anti-spasmodic drugs such as opium and the bromides has not proved of the slightest value in my experience. Of course, infinitesimal doses of opium cannot be expected to do any good, but I have pushed the drug to its full physiological effects without any benefit whatever. Nor does it appear likely that the drug would have any special action on the circular fibres of the pylorus and fail to affect the longitudinal fibres to an equal extent. In cases of marasmic infants suffering from this affection, with all the tissues dried up, the use of saline injections both subcutaneously and per rectum has seemed beneficial. From four to ten ounces of normal saline solution can be given daily and will act as a restorative until the improvement of the pyloric function allows of the entrance of a sufficient amount of fluid into the system by the natural route. In cases in which the infant is much reduced or has a subnormal temperature brandy, up to half a drachm daily, will be found of service as a general tonic. The administration of cod-liver oil by inunction, if it be of any value, would appear to be specially suited to the conditions present in this affection. I have only employed it once and in that case a skin eruption quickly followed and led to its discontinuance.

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ON TERTIARY SYPHILITIC FEVER AND THE VISCERAL AND OTHER CHANGES CONNECTED WITH IT.

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A GOOD deal has been written on the subject of fever, especially protracted fever, in tertiary syphilis,¹ but my attention was first directed to the subject by Mr. Campbell Williams and by the patient himself whose case Mr. Williams described at the Clinical Society in 1900 as "A Case of Late Syphilitic Pyrexia (Intermittent Essential Fever of Syphilis)."²

The first patient, a married woman, aged 36 years, was under my care at the German Hospital from May 1st to June 17th, 1906, and again from August 27th to Sept. 10th, 1906. She had previously been under my care at the Mount Vernon Hospital. The patient's husband, a fairly healthy-looking man, admitted that in 1893 he had a sore on his penis. He was only three or four weeks under treatment for it and as far as he knows there were no secondary symptoms. (The husband's history was not, however, obtained till the clinical evidence of syphilis in the patient's case was conclusive.) The patient had had no children since 1893, but of the two children born previously one was living and healthy and the other died in infancy. She had had no miscarriages. She had certainly been accustomed to indulge somewhat freely in whisky. Up to 1900 she enjoyed fair health but about that time a good deal of the hair of her head came out and she began to suffer from depression, languor, occasional vomiting, and occasional night-sweats. About 1902 she had "rheumatism," principally in her knees. In December, 1904, she first brought up blood and became subject to nausea, vomiting, and inability to take food. In 1905 she occasionally brought up blood (hæmatemesis or hæmoptysis); usually she first coughed and then vomited, the vomiting being followed by bringing up the blood. There was no history of jaundice. From childhood she had often had sore throats. She dated her present deafness from 1905. In August, 1905, sores formed about her left ear which were preceded by lumps. From Dec. 1st, 1905, to March 7th, 1906, she was in the Mount Vernon Hospital. On admission she was found to have considerable enlargement of the liver and spleen, pains in the lower extremities, and an irregular type of fever, occasionally over 102° F. On two occasions (Dec. 4th and Jan. 8th) she was said to have had coloured expectoration, but no definite signs of any disease in the thoracic organs could be discovered except some dulness at the base of the right lung corresponding to the enlargement of the liver. On one occasion I noted that the liver and spleen were hard, had a

¹ See Sidney Phillips, A Case of Syphilitic Fever resembling Tertian Ague, *Brit. Med. Jour.*, Nov. 30th, 1889, p. 1217; J. H. Musser, The Diagnostic Importance of Fever in Late Syphilis, *University Medical Magazine*, Philadelphia, October, 1892, p. 6; E. G. Janeway, Danger of Error in Diagnosis between Chronic Syphilitic Fever and Tuberculosis, *American Journal of the Medical Sciences*, September, 1898, p. 251; D. W. Prentiss, A Case of Syphilitic Fever, *Philadelphia Medical Journal*, July 29th, 1899, vol. iv, p. 215; A. C. Morgan, Syphilitic Fever, *Philadelphia Medical Journal*, Feb. 17th, 1900, vol. v, p. 360; C. Gerhardt, Syphilis einiger innerer Organe, *Berliner Klinische Wochenschrift*, Nov. 12th, 1900, p. 1046; T. B. Fletcher, Syphilitic Fever with a Report of Three Cases, *New York Medical Journal*, June 22nd, 1901, p. 1065; F. Klemperer, Ueber Fieber bei Syphilis der Leber, *Zeitschrift für Klinische Medizin*, Berlin, 1904, vol. lv, p. 176; A. Birt, The Fever of Late (Visceral) Syphilis, *Montreal Medical Journal*, October, 1905, vol. xxxiv, p. 748; L. D'Amato, Sulla Febbre Sifilitica Terziaria, *La Riforma Medica*, Naples, March 10th, 1906, No. 10, p. 253. Both Birt and D'Amato refer to many papers on the subject. F. Klemperer also alludes to observations by G. Klemperer, C. A. Ewald, and others. J. S. Bristowe (*Clinical Society's Transactions*, London, 1886, vol. xix, p. 249) and T. D. Savill (*Clinical Journal*, London, Dec. 1st, 1897, p. 87) have both drawn attention to the occurrence of chronic hectic fever connected with gummatous disease in congenital syphilis. One of the earliest authors to draw attention to the possible occurrence of a hectic type of fever in tertiary as well as in early syphilis was C. Bäumler who whilst still in London wrote a paper, Ueber das Verhalten der Körperwärme als Hilfsmittel zur Diagnose einiger Formen Syphilitischer Erkrankung, *Deutsches Archiv für Klinische Medizin*, Leipzig, 1872 vol. ix, pp. 397-432. Fever up to about 102° F. is mentioned in H. Weber's account (*Transactions of the Pathological Society of London*, 1866, vol. xvii, p. 152) of a case of very extensive tertiary syphilitic disease in the liver, lungs, bronchial glands, dura mater, cranium, and sternum. J. E. Guntz, a pupil of Wunderlich, was the first to make accurate thermometric observations on the fever of the early stages of syphilis, the occurrence of which was already known to John Hunter.

² *Transactions of the Clinical Society of London*, 1901, vol. xxxiv, p. 28.

PASSMORE EDWARDS COTTAGE HOSPITAL, LISKEARD.—The annual meeting of the subscribers to this hospital was held on Feb. 26th. The medical report stated that 78 in-patients and 30 out-patients had been treated during 1906, being the highest number on record. The financial statement showed a small favourable balance. The committee decided to elect all the members of the medical profession in the town as honorary members of the staff, with Dr. R. H. Lucy as honorary consulting surgeon, Mr. J. R. Rolston as honorary ophthalmic surgeon, and Mr. W. H. Lyne as honorary dental surgeon.