It is of further interest that C. F. J. himself came down with the disease after the outbreak had nearly subsided, and that dealer "A's" son, who drank milk from C. F. J., was one of the earliest victims. The partner of dealer "B" was seized on April 18 and at about the same time also another member of his household.

COLD AIR IN INCURABLE CONSUMPTION.

BY HERBERT C. CLAPP, M.D., BOSTON,

Visiting Physician to the Massachusetts State Sanatorium for Incipient Consumptives at Rutland.

NOT long ago the trustees of the Boston Consumptives' Hospital invited a few physicians to come to one of their meetings prepared to make suggestions as to the planning and construction of their proposed hospital buildings at Mattapan. They announced that they intended to receive cases of the disease in all stages which were not acceptable at the State Sanatorium at Rutland.

In the presentation of views which followed, one or two of the invited guests expressed the opinion that, as regards exposure to fresh air during the different seasons of the year, all cases of consumption should be treated *exactly alike*,—the far-advanced as well as the incipient, and all the grades between.

As I could not entirely agree with this doctrine, I tried to express my dissent, but fear that on the spur of the moment I did not say exactly what I meant. I now desire to put into writing the opinions which I can in this way express more clearly than in hasty extemporaneous speech.

Having seen in many hundreds of curable cases of pulmonary tuberculosis in New England the really wonderful effects of constant exposure to large amounts of fresh air, especially in the winter time, no one could be more enthusiastic than I in recommending for such cases this treatment in all its thoroughness.

Unfortunately, however, if the disease has passed beyond a certain stage, this method, either alone or combined with any other therapeutic measures whatsoever, completely fails in inducing recovery in the vast majority of cases, although in them a temporary improvement may sometimes follow.

It is, of course, impossible for the best physician always to state with absolute infallibility just exactly what patients are incurable; but practically every fair-minded man of experience will admit that there are a great many cases which come to the physician which he can decide to be thus incurable with every prospect of having time prove his decision to be correct in all but exceedingly few instances.

Now, admitting this, shall we give to such consumptives as these as much cold air as we would give to incipients? I should say that sometimes we should and sometimes we should not. Of course, I presuppose that nowadays everybody would advocate what is generally called "good ventilation" even in the worst of these cases, the windows being open more or less and the

room being heated; but this is not the modern fresh air treatment.

For our present purpose we can divide incurable cases into four classes: First, those who really enjoy the cold air; second, those who dread it and really suffer from it; third, those who dread it and suffer from it but think they ought to submit themselves to it; and fourth, those who are indifferent.

As to the *first* class, those who have been properly trained in sanatoria or in private practice as a rule gradually learn to love the fresh air so much that they cannot get along without it and are not happy unless they have it. By all means let them continue to have it.

In the *second* class are generally those who first come to us in the incurable stage and who have not hitherto had the fresh air treatment. Many of them, perhaps from improper habits of thought and living, dread the cold air and suffer severely if compelled to endure it, and beg to be allowed to be comfortably warm. Repeated trials in actual life prove that they never do get used to the cold. They should not be compelled to endure it against their wills.

The *third* class of incurables comprises much the same kind of people except that they have more will power and perhaps more endurance. They are not willing to admit their incurability. They know from the common talk that fresh air is a powerful factor in the cure of consumption; and with the heroism characteristic of old martyrs they make a stern resolve to submit themselves to it at whatever cost of comfort. In like manner, to increase their chances of getting to heaven, some of the old enthusiasts of a former generation, deeply imbued with the religious ideas of their times, and especially apprehending the beauty of self-sacrifice, voluntarily walked with pebbles in their shoes or inflicted on themselves some other unnecessary tortures. They were willing to inconvenience themselves for the object to be gained. If they had lived in these times, perhaps some of us might have tried to persuade them that such self-abnegation as that, and such useless sufferings did not materially increase their chances. So with these hopeless consumptives, it is pitiful to see them voluntarily incurring discomfort without receiving any adequate return. To be sure, some of them might breathe a little easier for it, but in most cases their sufferings certainly outweigh any benefits received.

The *fourth* class, the indifferent, we should try to persuade to have abundance of air, if not disagreeable, and sometimes we may succeed and sometimes not. In all cases, however, we should respect their freedom of choice.

In fact, in my opinion, the last point is the keynote to the whole situation with all four classes. If we have good reason to think that they cannot get well, let us be really kind to them by allowing them to choose (perhaps after trying both methods) whether they shall be continuously exposed to the cold fresh air of winter or not.

In order to give them this choice, hospital

buildings designed for such incurables should be more substantial in character than the cheap shacks often used for cases which belong to the possibly curable class, and should be capable of being well heated.

At this same meeting it was also argued that if any discrimination were made as to exposing patients to fresh air, those who received the least would thereby consider themselves as notified that they were incurable and would be correspondingly unhappy, and that this was a further reason that all should be treated alike.

Now I believe that the old-fashioned *spes phthisica* has not yet been abolished, but rather intensified, since the days of the marvelous increase in the percentage of recoveries from tuberculosis; and I doubt if a large number of patients would seriously take this implied notification as meant for themselves. When a clergyman points out the sins of his congregation, each one complacently thinks his neighbor is meant and not he. The incurable consumptive can foresee the fatal ending of the other man's case much easier than that of his own. He himself is going to get well after a while.

But, on the other hand, even if our willingness to allow him to be warm and comfortable does suggest to him an unfavorable prognosis, is this really undesirable?

On account of religious or financial or other reasons a great many people consider it their duty to tell those who are near and dear to them if they are not likely to live, in order that they may make proper preparation. Not infrequently even then they refuse to believe it. From a moral standpoint some people think it actually wrong to deceive advanced consumptives, when we think they have little or no chance of recovery; and it is very doubtful if at such times a lie either by word or implication materially increases their chances. So that, it seems to me, this argument is not prohibitive of our giving such patients their perfect freedom of choice as to exposure to the cold air of our New England winters. If others of large experience think differently, I should like to know it.

Medical Progress.

PROGRESS IN PEDIATRICS.

BY THOMAS MORGAN ROTCH, M.D., BOSTON,
AND
JOHN LOVETT MORRE, A.M., M.D., BOSTON.

STENOSIS OF THE PYLORUS IN INFANCY.

THIS condition is attracting so much attention at present that it seemed worth while to take up the literature of the subject, a subject which most of the readers of the JOURNAL are undoubtedly already somewhat familiar with. Dr. C. L. Scudder published a carefully described case in this journal April 27, 1905. Drs. Townsend and Scudder detailed another case, with operation and recovery Dec. 14, 1905. Dr. Scudder contributed to the JOURNAL another and more important article Feb. 22, 1906. In the meantime

Drs. Scudder and Quinby contributed a fuller statement to the *Journal of the American Medical Association* May 27, 1905, which contained an analysis of 115 cases, and brought the subject very well up to date. They state in this paper that they "very much doubt the permanence of the cure in cases treated medically," and that "to withhold operative treatment after the diagnosis of pyloric obstruction has been made, leaves the case practically hopeless, according to the evidence available." They quote Monnier as thinking that the mortality without operation is about 80%, and say that they "are persuaded that if the truth were known, the medical mortality would be above this figure." They quote 60 operations, with 32 recoveries and 28 deaths, giving a general mortality of 46.6%. These operations were performed by 28 different men in the seven years after 1898. They state that "no apologies are needed to the critics of surgery for the comparatively large mortality of 46.6%. Had not these particular cases been operated on, they all probably would have died. Many were almost moribund when placed under surgical care. Medicinal treatment has yet to demonstrate its power to cure this affection. Surgery, on the other hand, has proved its ability under adverse circumstances to cure more than half the cases intrusted to it."

A moderately careful review of the available literature shows that a considerable number of cases have been operated on recently, and that a number of others have been reported as cured by medical treatment. As in the past, the cases have been reported by the Germans, English and Americans, although the French are now beginning to recognize the disease. Some mistakes may have been made in analyzing the English cases, as some of them have been reported in several different places.

Thirty-one cases have been operated on by 22 different operators, with a mortality of 15, or 47%; no improvement over that in past years, although better figures might have been expected because of the better knowledge of the disease and the greater experience of the operators. The 15 fatal cases (Barling, Carpenter [3], Carpenter and Mummery, Cautley, Fischer and Sturmdorff, Morse and Murphy, Nicoll, Ramsey, Robertson, Rogers, Sutherland, Thompson, Walls and Andrews) were operated upon by twelve men, the time of the operation after the onset of the symptoms being two and a half, three, three, three, four, four, five, five, ten and twenty-two weeks in the cases in which it was noted. Death occurred in eight cases in thirty hours or less; one died in five days of bronchopneumonia, one suddenly in five days without apparent cause, another in two weeks from peritonitis caused by a hernia of the bowel, and still another after two weeks from gradual failure. Gastro-enterostomy was done in nine cases, a Loreta operation in two, and a pyloroplasty in another.

The 16 cases (Capps and Bavan, Cautley, Keefe, Kimball and Hartly, Nicoll [5], Rogers and Howland, Sarvonat, Scudder, Townsend and