working classes with midwives, whom we would never dream of employing for our own wives or for the well-to-do, should be dropped. The poor and the wage-paid classes are already more than amply provided for. Let medico-ethical societies and others interested see that the existing powers are put into force and honestly administered. Our duty as medical practitioners to the public, to pregnant women, and to infants in this great obstetric question is truly enormous. The fact that, with our parrot-like garrulity and boasting of the results of "antiseptic midwifery," the number of women who die now is, even with "cooked" statistics, very little less than the number who died years ago, should appeal to us, not only as men but as obstetric practitioners, and should make us shun those who would divorce the study and practice of obstetrics from that of medicine and midwifery. Such persons would have us return to those death-dealing days when pregnant women were not given the benefit of educated practitioners. In 1827 the Royal College of Physicians of London described midwifery as "an act foreign to the habits of gentlemen of enlarged academic education," while later it had actually the effrontery to refuse its highest diploma to those who dared to practise midwifery. These are the predecessors of this College who in 1891 humiliated themselves by reporting to the General Medical Council in favour of midwives registration, evidently showing by their action that "the evil which men do lives after them." In 1843 even the Royal College of Surgeons of England refused their Fellowship to those who practised midwifery; while in 1733 the Royal College of Physicians of Ireland earned an historical disgrace by refusing their Fellowship to Sir Fielding Ould, a practitioner whose "base crime" was that he had been guilty of saving the lives of thousands of women and of infants. It is seldom the bright pages of medical science have been so bedaubed; but it only shows that history repeats itself when in 1896 we have a few practitioners forming a private obstetrical society and selling pseudo-diplomas to midwives, and when a few others, trying to make legal their illegality, try to smuggle a Midwives Bill through the House of Commons. To-day we are threatened with a revival of medical Pharisaic cant—the worst and most dangerous of all cant. The question is, Are we medical practitioners to range ourselves on the side of humanity and of justice to poor women; or are we, like mendicants, to be dictated to by a number of faddists, by a few society ladies who have nothing to do, and by a few self-styled "leading" practitioners who have so far forgotten themselves as to attempt to repeal the life and health-saving provisions of the Medical Act of 1886? It is for practitioners and for them alone to decide. If each practitioner when a new Midwives Bill is introduced will at once write to the Member of Parliament representing his division and ask him earnestly to oppose such Bill, this will prevent it from passing. I would ask that practitioners do not lend themselves or be parties to a revival of that atrocious cant and hypocrisy which has left a permanent stain upon the colleges, upon those supposed to be the leaders of a humane calling, and which has been the means of causing the death of an immense number of women and infants. Each year women, and especially women residing and working in cities and towns, seem to be becoming weaker and less fit to undergo the great trials of maternity and nursing their young infants. The supposed "natural" act of confinement and good recovery therefrom are becoming more "unnatural." Therefore I ask, Is it fair that under all these circumstances women should be denied a full share of all the improvements in our knowledge of obstetrics? If it be fair, then I reply to those who say so that to be consistent they should when ill not share in the advancements made in medical and surgical science, but should call in the aid of only the "medical" herbalist or bonesetter.

As the General Medical Council will be again called upon by me to deal with those who issue bogus diplomas in midwifery, &c., I wish to ask each medical society to adopt the following motion:—"At a meeting of the, composed of members, duly convened and held at on the day of, 1897, Dr. in the chair, the following motion, proposed by Dr., seconded by Dr., was agreed to, 'That on and after June 1st, 1897, whenever any registered medical practitioner or any practitioner entitled to be registered (other than practitioners empowered by the Medical Act, 1886), either directly or indirectly issues, or sanctions, or takes part in the issuing of, any instrument or document which professes to empower the holder of such instrument or document to practise, or ot

hold themselves out as being in any way entitled to practise any part or branch of the practice of medicine, or of surgery or of midwifery, such practitioner so doing shall, on due proof being given, be judged by the General Medical Council to have been guilty of infamous conduct in a professional respect and his name shall be erased from the Medical Register and any registerable qualification taken from him to the body or bodies which granted such.' That the secretary forward a copy of this resolution to the President of the General Medical Council, 299, Oxford-street, London, to the medical journals, to Dr. R. R. Rentoul, and the four other Direct Representatives."

If the majority of practitioners object to adopt this motion, then it must follow that as their direct representative upon the General Medical Council I must let this most vital question drop. But if they adopt this motion and send it to the General Medical Council then I can say, and say fearlessly, that I speak for and in the name of my constituents and in the interests of the public health.

CREOSOTE IN THE TREATMENT OF PLEURO-PERITONEAL TUBERCULOSIS IN CHILDREN.

By PROFESSOR THOMA.

PERITONEAL tuberculosis in children has for several years been treated by laparotomy, and the results are often very good. We have learned, also, to distinguish the different forms of this disease, so that its diagnosis and treatment are easier than formerly. Laparotomy is no doubt the best and quickest of all methods for dealing with those cases in which the peritoneum is covered with miliary tubercles; but it is always a serious operation and one also which not every medical practitioner is competent to perform. Moreover, the parents of the little patients are usually averse to surgical interference and anxious for the employment of some other means, so that it is not surprising that physicians should welcome a non-surgical treatment of this dangerous illness. In former years general tonics, painting with collodion, and the local application of iodine were principally relied on; but the results were often bad. Ichthyol has been employed of late years; it is certainly a good remedy, and in spite of its disagreeable smell I have many times used it with satisfactory results in acute inflammations of the peritoneum. It has frequently happened, however, that these various methods were either ineffectual or else so tedious that children were obliged to stay too long in the hospitals.

Not long ago the idea occurred to me that in these cases creosote might be advantageously administered in enemata. The first writer who recommended this treatment was Dr. Revillet of Cannes, but he employed it only for the treatment of phthisis, and after him many physicians have had favourable results. Sometimes this substance disagrees with the patients, causing diarrhoea and pains in the abdomen, so that it has either to be discontinued or combined with acetum opii ("black drop"), but this adjunct does not always succeed and is often contra-indicated. Another difficulty is the necessity for the patient's retaining the enemata as long as possible, in order that the creosote may be completely absorbed. With very young children this is hardly possible, but with my two little patients it was very easy. The enema was given each evening when the child was quiet and before putting the patient to bed. At first the child could not retain the enema more than three or four hours, but after some days the child slept well and on many occasions only a little oil was found in the morning along with the first motion of the bowels. Dr. Revillet directed the enemata to be prepared with water, a small quantity of almond oil, and the yolk of one egg. Recently, however, it has been proposed by a chemist of Grenoble to administer creosote in milk; forty-three drops of creosote are mixed with a quarter of a glass of milk and water is afterwards added. This method is evidently more simple and has the advantage that the milk is taken by the mouth, for everybody knows the difficulty of feeding an unwilling child. Nevertheless I prefer the association of

cod-liver oil with creosote. In an interesting memoir presented to the Faculty of Medicine in Geneva, Dr. Loppino, confirming the experimental researches of Professor Schiff, has proved that fat is very well absorbed by the rectum, and that oleaginous injections are highly important agents in combating emaciation and cachectic states. Dr. Loppino has never seen any bad effects resulting from the practice; the best results were obtained in the case of neurasthenic and tuberculous patients, and it is a useful mode of carrying out the treatment by over-feeding introduced by Dr. Weir Mitchell. This circumstance induced me to try enemata composed of a mixture of cod-liver oil with creosote. At the outset each enema contained 150 grammes (about four ounces) of emulsified oil and 0.5 gramme (8 grains) of creosote, but after from eight to ten days I gave 1 gramme ($=15\frac{1}{2}$ grains) of creosote. In the first case the child took in the course of some days 1.5 grammes of creosote; diarrhoea ensued, and the enemata had to be discontinued. After the treatment has been continued for some weeks it is a good plan to suspend it for five or six days and begin again. I have not noticed that the taste of creosote was perceived by the children; their appetite was somewhat impaired at first, but it was not lost and it subsequently improved. By this method it is possible to relieve the disorders of the bowels so frequent in this illness. I think that the antiseptic action of creosote is valuable against intestinal fermentations; it is not unusual to find constipation alternate with diarrhoea in the first stage of tuberculous peritonitis, an important cause of that condition being weak digestion and the slowness or rapidity of the movements of the intestines. The antiseptic action of the mixture of cod-liver oil and creosote is very efficacious against these troubles and after some days an improvement will be seen. The absorption of the creosote was unquestionable, for on many occasions the urine was dark-coloured. It is possible that creosote may have a curative effect on tuberculous deposits.

The first of my cases was a boy, eleven years of age, whose father and mother were alive and in good health; one sister of the mother died from tuberculosis some years previously; the child had often been to see her and was kissed by her. In August, 1894, he fell ill with pleurisy on the right side; the attack lasted fifteen days but he seemed to recover perfectly. In November he suffered from cough; in February, 1895, he lost his appetite, became very weak, suffered from abdominal pains, and went into the hospital on March 1st. On admission he was thin and feverish, his evening temperature being 38.5°C . His tongue was thickly coated and he had no appetite, but there was no vomiting. The abdomen was distended, but not very painful; there was retraction of the hypogastrium, but no indication of ascites. Some obstruction was felt on deep palpation, and there was diarrhoea. The urine was normal. The patient had a little cough, and on the left side there was weak respiration with ægophony; the breath sound was rough and the expiration prolonged at both apices. Milk diet was given, a blister was applied over the left lung, and ichthyol on the abdomen. On March 7th the signs of pleurisy were increased. An enema containing nine grains of creosote was administered. On the 14th the enema was retained for eight hours and caused no pain. On the 16th an enema containing 15 grains of creosote was given. The diarrhoea had now ceased, and the condition of the left lung was also better. On April 10th slight ascites was recognised, but the abdomen was less distended and more yielding. On the 20th the amount of creosote was raised to eighteen grains, and the patient's state, both general and local, improved. On the 27th slight diarrhoea necessitated the temporary discontinuance of the creosote, as the last dose had been too large; but after a few days the treatment was resumed, and on June 25th the patient's general state was very good, the lungs and abdomen being normal. He then went into the country. I saw him on Aug. 17th, and found that the improvement was fully maintained; on Oct. 5th he set out for Cannes in perfectly good health.

My second case was that of a girl, seven years of age, whose father and mother were in good health. In 1890 she suffered from influenza and bronchitis and from frequent cough since that date. In March, 1895, her strength and appetite failed. On March 26th fever and cough set in and on the 29th she was admitted into the hospital. She was at that time anæmic and thin and had symptoms of general bronchitis; on the right side there was a harsh breath sound, with bronchophony and signs of slight dry pleurisy. There were also diarrhoea and loss of appetite, but there was no vomiting.

The abdomen was distended, with some retraction in the lower part; there was no ascites; the intestines seemed to be matted together. The treatment consisted in the application of ichthyol to the abdomen and the administering of an enema with nine grains of creosote, but after some days the dose was raised to fifteen grains. The symptoms of bronchitis gradually subsided and on May 30th the abdomen was less distended, but it was necessary to make an application of collodion to it. On July 1st the abdomen was yielding and free from pain, the diarrhoea had ceased, the appetite was good, and the general health was excellent. The child weighed 20 kilogrammes ($=44\text{ lb.}$), being a gain of 3 kilogrammes ($=6\frac{1}{2}\text{ lb.}$). She then went home, but returned to the hospital in the month of August, having partaken too freely of fruit, which had caused diarrhoea. After some days of ordinary treatment the diarrhoea ceased and at the end of September the patient's health was very good.

Of course it is inexpedient to generalise from two cases, especially as these children were not very ill and were treated promptly; but, keeping in mind the comparatively short duration of the treatment and the necessity for preserving the appetite and the digestive functions as unimpaired as possible, it seems to me that enemata of cod liver oil and creosote are well tolerated and give good results.

Geneva.

A NOTE ON THE GLANDULAR FEVER OF CHILDHOOD.

BY DAWSON WILLIAMS, M.D., F.R.C.P. LOND.,
PHYSICIAN TO THE EAST LONDON HOSPITAL FOR CHILDREN, SHADWELL.

UNDER the name "glandular fever (Drüsenfieber)" E. Pfeiffer,¹ in 1889, described a condition observed in childhood which he contended was an acute specific fever hitherto unrecognised. The symptoms of the disorder as noted by him and elucidated by subsequent writers are briefly as follows: The patient, a child under fourteen years of age, becomes suddenly ill, the temperature is found to be raised— 101° to 103°F .—there is anorexia, nausea, sometimes vomiting, coated tongue, constipation, and, perhaps, some ill-defined abdominal pain. The most prominent and characteristic symptoms, however, are stiffness of the neck, tenderness in the anterior triangle, and some pain on movement of the head and on deglutition. There may be some undue redness of the pharyngeal mucous membrane, but throughout the whole course of the illness nothing like definite pharyngitis or tonsillitis. On the second or third day a swelling is noticed in the neck, which is found to be due to three or four enlarged lymphatic glands, which can be felt beneath the sterno-mastoid muscle and along its anterior border. The temperature becomes higher and usually touches 104°F ., and the ordinary symptoms of pyrexia are present. The glands, which are tender, remain swollen for from two to five days and then begin to diminish. The glands first affected are as a rule those of the left side, and the pain on movement may lead to the head being flexed towards that side. Before the glands on the left side have begun to subside those on the right begin to enlarge and in a day or two attain a size corresponding to that reached by those on the left side when at the maximum. Tenderness of the abdomen may be a very marked symptom, and in a large proportion of cases the mesenteric glands can be felt to be enlarged. The liver is enlarged almost invariably, and the spleen in more than half the cases. The other cervical glands may also become enlarged, the axillary and inguinal glands less often. The disease is mild and is seldom or never the direct cause of death, but it leaves the child in an anæmic and depressed state, which may last long after all trace of enlargement of the lymphatic glands—which has usually ceased in ten days or a fortnight—has disappeared.

It is obvious that the specific characters of the disorder are not well marked. Enlargement of the cervical glands secondary to various local lesions is of so common occurrence in childhood that the specificity of Pfeiffer's "Drüsenfieber" has not met with general acceptance. It can hardly

¹ Jahrbuch für Kinderheilkunde, Band xxix. According to Protasow (loc. cit., Band xxxii., s. 365), the condition had been described by Filatow of Moscow at an earlier date.