Dispensary of the present day, with, not only an apothecary to dispense medicine for the poor, but also the regular attendance of a full medical staff embracing one for every recognized specialty, ready to give *special* attention *freely* to the diseases of each organ or group of organs composing the human body, had no existence in our country, at that day. If the physician or surgeon in full practice found more poor patients coming than he could find time to attend to, he sent them to the nearest well qualified young doctor who was waiting for calls and glad to take them, both for the clinical experience he would get and the almost certainty of their proving stepping-stones to other cases that would pay. But the rapid development of *specialties* brought, *pari passu*, the disposition of medical students to educate themselves for *special* or limited fields of practice, and the equal education of the community to look for a special doctor for each region of the body. This soon necessitated the invention of some method by which the young specialist could get himself introduced to the public, and as the Code of Medical Ethics, whether written or unwritten, would not allow them to flood every man's door-steps with hand bills illustrated with the cut of an eye, ear, uterus, speculum or stethoscope, the next thing available was to utilize the public sympathy for the sick-poor in establishing Dispensaries, Infirmaries, Asylums, Special Hospitals, Clinics and Policlinics, for each of which there must be the names of a few prominent business men or women to serve as trustees, managers, or its patrons, and a medical specialist for each class of diseases the institution is intended to accommodate. By this process the young doctor secures a public position which at once brings him in contact with some prominent members of the community, and in plain English, advertises him as a specialist and a liberal friend to the poor. Meantime he has his regular office fitted up in good style for the reception of ordinary patients, and both for the purpose of securing sufficient revenue and duly impressing his customers with the importance of *special* qualifications, he must charge not less than *five dollars* for the most ordinary examination.

Now, with the same *specialist*, or even non-specialist, making a minimum charge for patients at his own office, equal to what most working women can earn by not less than two weeks' hard labor, and at another part of the same day bestowing the same services at the Dispensary for nothing, how long does it take the laboring classes of both sexes to learn the avenues open to them, and to arrive at the conclusion that they are not able to pay the amount of one or two

weeks' wages for the same professional services that they can get at the Dispensary for nothing. It is exactly this kind of machinery, invented and fostered by the profession itself, that has, during the last three decades, filled all our cities with so-called medical charitable institutions, converted tens of thousands of the working classes from moderately paying patients into full medical mendicants, and robbed the younger class of medical and surgical practitioners of the patronage of the very class of honest working people, that formerly constituted the chief avenue through which they gained in a few years reputation and full practice. If the members of the medical profession have thus fostered a system of extravagant specialism and equally redundant medical charities, by which they find their own pockets empty, the principal blame is upon themselves, and it will require something more than the closer questioning of the applicants at the door of the Dispensary concerning their pecuniary circumstances to correct the evil.

SOCIETY PROCEEDINGS.

CHICAGO MEDICAL SOCIETY.

Stated Meeting, Nov. 1, 1886.

E. J. DOERING, M.D., PRESIDENT, IN THE CHAIR.

DR. ALBERT E. HOADLEY read a report of FIVE CASES ILLUSTRATING A TREATMENT OF THE MORE SEVERE FORMS OF STRICTURE OF THE RECTUM.

Case 1.—J. H. G., an engineer, æt 40, with history of piles of eight years standing and stricture two years. Examination revealed a hard carcinoma of the rectum within one and a half inches of the anus, immovable on account of adhesions to the sacrum. The adjacent parts were involved and the bowel completely occluded. The general condition of the patient was bad. Abdomen swollen and very tender. Had not had a passage from the bowels for two weeks. Could not take food without immediately vomiting. Pulse feeble, 120, temperature 102°. At the first examination Dr. Hoadley succeeded in separating the adhesions sufficiently to pass a syringe pipe beyond the immediate stricture. A half-pint of soap water was injected a number of times during the afternoon and evening with the effect of bringing away considerable matter and gas and giving great relief to the patient. Three operations were performed at intervals by which a fair canal through the cancerous mass was made, but without relief to pain. At the fourth operation the lower end of the growth and sphincter ani were divided with one stroke of the knife. There was little hæmorrhage. The relief obtained by the division of the sphincter was tenfold greater than that from all the other operations.

Case 2.—A laborer, forty-two years old, with history of hæmorrhoids, and stricture of five years standing. Examination revealed a firm unusual stricture within two inches of the anus. Syphilis could not be excluded as he was put on large and increasing doses of pot. iod., and a systematic dilatation with an elastic bougie commenced. After four weeks a bougie one inch in diameter could be passed without difficulty. There was no particular irritation at the seat of the stricture, but the bowels were very irritable and there was an increasing diarrhœa. The stricture and sphincters were thoroughly divided and the wound packed with gauze on which dry per-sulphate of iron had been sprinkled. Relief was immediate and complete. Examination two months after the operation showed the wound to be nearly healed and the patient feels better than he has felt for a year previous.

Case 3.—An American woman, aged thirty-nine, the mother of three children; she had a stricture of nine years standing. When the stricture was divided it was found that the rectum contained a carcinomatous mass, almost occluding the canal, higher than could be reached with the fingers. The sphincters were divided back to the coccyx and an incision was made through the mass nearly to the sacrum, and a piece of gauze pressed on the wound to prevent bleeding. A large-sized drainage tube was placed in the bowel above the disease. The rectum was packed and all secured with a T bandage and the patient put to bed. After the fifth day she rapidly improved and left the hospital within a week after the operation. Three months afterward she was comfortable and had gained six pounds.

Case 4.—A German woman of fifty six years, the mother of several children. She had enjoyed good health until the development of the stricture of the rectum about three years before. The stricture and sphincters were divided, and on introducing the finger the bowel was found blocked up with other strictures of a malignant character. These were dilated with the fingers. A violent inflammation supervened and the patient's life was threatened. She made a slow recovery and was convinced that she was made worse by the operation. Dr. Hoadley thought that if the strictures had been incised instead of divulsed, the patient would have derived benefit.

Case 5.—An American of sixty-seven years, the mother of four children. Labor had always been normal and easy. She had a stricture of five years standing. Examination revealed two or three open sinuses and fluctuating abscesses in the ischio-rectal region. The abscesses and sinuses were opened and packed with iodoform gauze and the stricture divided, the sphincter being simply dilated. Great relief followed the operation which was made to relieve pain and not with the hope of prolonging life. From a study of these cases, Dr. Hoadley deduced the following principles:

First, it is dangerous to practice divulsion of malignant stricture of the rectum; second, division of a severe stricture of the rectum without dividing the sphincters is of little practical value and has no

tendency to cure; third, division of malignant strictures with the sphincter gives great relief and tends to prolong life; fourth, division of severe non-malignant stricture with the sphincters gives great relief and tends to perfect cure; fifth, division of both stricture and sphincter whether malignant or non-malignant is not attended with danger. Therefore we may conclude, that in all severe strictures of the rectum, whether malignant or non-malignant, complete division of the stricture and all the tissues below it back to the tip of the coccyx affords the greatest relief and of the non-malignant strictures, the best means of permanent cure at our command.

Dr. J. FRANK thought that if the author had divided his paper into relief for malignant strictures, and treatment for non-malignant strictures, it would have been a better classification. He had not had much experience with malignant strictures, but had divided one in the manner described by the author, by cutting down through the cellular tissue. He thought there was little danger in performing the operation, and was surprised at the small amount of hæmorrhage. But the benefit from the operation lasted only for a short time, there was relief at first but in six or eight weeks the same symptoms returned. Even in extirpated cancerous growths, as far as his information went, they generally return within a year. He had had one case in which the whole cancerous growth was extirpated, but in six or eight months it commenced to return and in a year's time the patient died with cancer. He thought that in dividing the strictures care must be taken not to go too far up the bowel, or too deep, as the peritoneum might be cut into.

Dr. A. E. HOADLEY in closing the discussion said: Dr. Frank suggests that we be careful in dividing the strictures high up; I think if we do not divide them higher than we can reach with the finger, dividing them in the posterior line, there is little danger of opening the peritoneal cavity. The peritoneum does not come down as a rule, where it can be reached with the finger. In regard to hæmorrhage, those cases sometimes bleed profusely even though they are divided right in the median line, where we least expect to find blood vessels; the tissues become vascular, new vessels form, and it is necessary to tampon the wound and in doing so it is best to put in a tube to relieve the bowels of gas. The suggestion made in reference to the division of the paper is quite proper; perhaps it would have been better to have said, report of cases illustrating a treatment. The treatment is palliative in malignant strictures, and in non-malignant strictures sometimes effects a cure. In answer to the question how many inches up may we go; it is a rather difficult matter to reach the peritoneum of the posterior wall of the rectum with the finger, even if the sphincter is divided; you can reach about four inches with the finger by pushing hard, and I think I would hate to divide a stricture further than I could reach with my fingers. Even the inferior mesenteric artery (superior hæmorrhoidal) comes down sometimes, before it bifurcates into the lateral branches, within reach of the fingers and may be

divided, but that is no drawback to the operation because you can put a tampon into the rectum so firm that all hæmorrhage can be perfectly controlled and on the next day you may remove about half of the tampon to relieve tension, and the remaining half will tumble out itself three or four days later. It has been my experience, and it is on the authority of the textbooks, that the vessels there can be controlled with the tampon very securely and with perfect safety. It is best to prepare for it and always tampon where you make that division, because moderate hæmorrhage is sometimes quite persistent.

DR. A. J. OCHSNER read a

REPORT OF A CASE OF ACTINOMYCOSIS,

with exhibition of patient. The patient, a stock raiser, aged fifty-six, entered the Presbyterian Hospital of Chicago, October 13, 1886. Until the autumn of 1877 the patient was in perfect health, following his occupation of stock raising. At that time he was exposed to drafts of cold air during a journey, and experienced severe neuralgic pains in the left antrum of Highmore. He had seven teeth taken from his upper jaw from which all the other teeth had previously been removed, but these proved to be sound and he obtained no relief by their removal. For six months he suffered excruciating pain in the left antrum and in both eyes from sunrise until sunset. In 1878 there was a spontaneous opening of the abscess into the pharynx evacuating a considerable amount of pus and some blood and giving the patient marked relief. A portion of the discharge usually entered the larynx at night, giving rise to severe cough. In May of that year the patient underwent a surgical operation, an opening being made into the antrum above the first molar and the cavity curetted and irrigated. The irrigation was continued two or three times daily for two years, during which time he suffered severely from pain and weakness. In the spring of 1882 the patient went to northern Mexico and spent the summer on the plains and among the mountains between that point and Colorado. His general health and strength were much improved. In July, 1885, the patient began to cough and continued to do so until his admission into the Presbyterian Hospital. During September, 1885 and 1886 he expectorated blood, but thinks it came from the posterior nares. Since the first of October, 1886, he has expectorated mucus and pus streaked with blood which undoubtedly comes from the lungs or bronchi. The patient has lost thirty-seven pounds in weight during the past two years; his position is stooping, chest full in front and a decrease of motion on the left side with dulness, roughened respiratory sounds and numerous mucous râles. Below the upper border of the fifth rib and throughout the right side the sounds are normal. The history of the patient led to a suspicion of actinomycosis of the left lung, which had primarily existed in the antrum. By a microscopic examination of the sputum the characteristic fungus was at once found confirming the diagnosis beyond a doubt. Dr. Ochsner considered the following facts of practical interest in connection with the case:

The patient has been engaged for more than forty years in raising, buying and selling large numbers of cattle. Many of these animals suffered from lumpy jaw, and it was his practice to cure them by freely opening the abscess, by crucial incision, extirpating as much as possible of the lump and introducing about one drachm of powdered arsenic into the cavity. Repeating this once or twice, usually effected a permanent cure.

DR. R. H. BARCOCK said: The case is one of exceeding interest from its rarity, and particularly as it is a case occurring in this country and one of very few that have been recorded, and in this case the diagnosis is so unquestionable that the interest is all the greater. We know that in cattle the disease is manifested by tumefaction in various organs, whereas in human beings it is by suppuration and metastatic abscesses. The disease in the human being may effect any of the organs, not merely the lungs, but particularly the viscera of the abdomen. I would like to ask Dr. Ochsner if there are signs of the disease having attacked other parts of the body than those mentioned, any symptoms which lead him to infer that the digestive organs or the stomach are infected.

DR. R. TILLEY said: This is certainly one of the most interesting questions that has been brought before the society for a considerable time. In the case presented to-night the disease seems to have originated in the antrum, and is therefore especially interesting to those engaged in treating affections of the nose and throat, and the teeth, as in the history of this case, there was a considerable amount of pain associated with the eyes, it is of interest to the ophthalmologist, and as it is now associated with the lungs, it is of interest to those engaged in the study of affections of the lungs. As this case together with the last case presented to the society, in all probability constitute the only indisputable cases that have appeared in English literature, I think it would be of sufficient interest to the society to ask Dr. Ochsner to carry the investigation still further and try and produce the disease by inoculation on one of the lower animals. I will move at the proper time that the Society place at Dr. Ochsner's disposal the necessary funds. I would suggest that Dr. Ochsner accompany his report with a diagram of the fungus as it appears under the microscope. I have looked at the various schematic sketches that are published, and I claim that it would be absolutely impossible for any one with only the information afforded in these articles, without further study, to diagnose the fungi as they appear in the specimens presented. In Dr. Belfield's book I think the diagram is more in correspondence with those we see to-night, but those that are in Councilman's article in Wood's Reference Handbook certainly do not present such an appearance.

DR. J. R. SKEER inquired the condition of the lung at the present time, whether cavernous or indurated.

DR. FRANK BILLINGS endorsed the remarks of Dr. Tilley, and thought the society should afford Dr. Ochsner means to carry on the investigation. It is

not quite settled how this fungus is carried from one tissue to another; in one case it has been proven that it was carried to the heart by ulceration into one of the jugular veins, and it is known that it will spread through contiguous tissue as through the diaphragm from the pleural cavity to the peritoneal cavity. A pure cultivation of the fungus has been made at Berlin.

DR. HAROLD MOYER said: There is great uncertainty as to the manner in which the fungus obtains access to the tissues. I would ask Dr. Ochsner if there is anything in history of this case that would clear up that point. Two very interesting cases have been recently reported, in one case lung actinomycosis was diagnosed during life, and after death of the patient a large actinomycotic mass was found in the lower portion of the upper lobe of the left lung, and in the center of the mass a piece of tooth was found. Israel (Centr. Bl. f. d. Med. Wes-sensch) demonstrated actinomycosis in the sputum of that case, and so far as I know it is the only case on record in which a diagnosis was made from the sputum. The other case bears on the manner in which the fungus obtains access to the tissues and is reported by Soltmann (Jahrb. f. Kinderhke). A child while at play swallowed a head of what is known as fox grass, which was followed by severe pain, difficulty in swallowing, and difficulty in respiration. In a few weeks the head of grass was discharged in an abscess at the left of the vertebral column. In less than six months this case developed actinomycosis. The theory of Israel regarding the first case is that the parasite was carried by the piece of tooth directly into the lung. In the second case the fox grass undoubtedly carried it directly into the mediastinum, which was followed by secondary involvement of the tissue of the lung.

DR. W. T. BELFIELD said: I would like to say in reference to Dr. Tilley's proposition, that experiments on the cultivation or transmission of this fungus ought to be made from fungi obtained from animals and not from man; if from the latter, from pus taken from abscess cavities around the jaws. The reason is that fungi obtained in the sputum are far more delicate in appearance and for preservation. I have found that after a few days they disappear or at least are extremely hard to find, and it is stated by those who have had a great deal of experience that the fungi obtained from the sputum are not so robust as those obtained from cattle or from pus cavities, aside from the air passages, in man. In justice to Dr. Schirmer, I would say that in the case reported by him, the fungus was recognized in the sputum and a diagnosis of lung actinomycosis was made.

DR. R. TILLEY said: The question with me was not that of producing the best possible sample of the fungus, but to place cases in question beyond dispute and give the society further opportunities of studying the question. Necessarily American physicians must be ignorant of the question as a whole because it is impossible to get that accurate information from literature that we can get from the study of the manifestations of the disease. I would not discriminate between this case and that of Dr.

Schirmer, on the contrary, if there is a probability of developing the fungus from pus, and an animal is chosen, I do not think there would be any objection to taking samples from both cases to inoculate the same animal.

DR. A. J. OCHSNER, in closing the discussion, said: As far as we know at present there is no evidence of the existence of actinomycosis in any other portion of the body; the probable reason of this is the fact that the patient has been exceedingly careful never to swallow any of the discharge from the abscess or any of the sputum. The accumulation of the fungus in the lungs is probably not sufficient for ulceration to have taken place into any of the other organs. The amount of sputum during twenty-four hours is between one and two ounces, and some days there will be one or two of these accumulations of actinomyces of considerable size and a few very small points, and on some days it is impossible to demonstrate actinomycosis. On Saturday there were, I think, a dozen quite large accumulations and quite a number of small ones, so that judging from the number we find in the sputum, and from the physical signs, which are a decrease in the motion of the left side, mucous râles, and very slight dulness on the left side above the fifth rib, the accumulations are not very great, and we do not find any signs of the existence of actinomyces in any other organ, which answers also Dr. Skeer's question concerning the condition of the lungs at present. Concerning the access to the tissue the patient had teeth removed from the left side of the upper jaw a number of times, during which time he was constantly handling animals suffering from lumpy jaw, which is the same as actinomycosis in man, and constantly handling objects that came in contact with these animals. Another point of interest which might give us some light as to the possible introduction of actinomycosis in man is this: The patient tells me that on the farm whenever one animal has lumpy jaw, a number of animals are very likely to have it soon after. This happens generally in the spring of the year, or late in winter, when animals are likely to rub their necks on the fences. He thinks these animals with lumpy jaw rubbing their necks on the fences are likely to leave some of the actinomyces and the healthy animals are likely to scratch their skin and break the hide, and in that way become infected. The plants are exceedingly small and could with great ease be introduced into the mouth and the cavities of the teeth, or into the jaw from which teeth had been extracted. Drs. Ross and Robison are treating the patient at present by means of the pneumatic cabinet, introducing into the lungs 1-1000 solution of bi-chloride of mercury. It seems that more of the actinomyces have been coughed up since this treatment began, but it has been of such short duration that nothing certain can yet be said.

The Committee on Pathology reported through Dr. W. T. Belfield the examination of the case of actinomycosis hominis presented to the society on September 6th. The patient is a man about twenty-five years old, emaciated and feeble. The lateral diameter of the neck is considerably increased by inflammatory thickening of the superficial cervical tissues which

are hard and unyielding; on either side of the neck is a ragged scar and small fistulous opening from which issues a slight serous discharge. The jaws could be separated to only a slight extent; but so far as could be determined, the mouth and throat presented nothing abnormal; no carious teeth were detected.

Dulness on percussion and broncho-vesicular breathing were found over the apex of either lung; on the left side in the supra clavicular region and first intercostal space anteriorly; on the right side down to the third rib.

The patient coughs frequently and occasionally raises considerably sputum. About an ounce of sputum was collected from which slides were prepared and several specimens of actinomycetes were detected.

September 28 an incision was made in the left side of the neck, giving exit to a small quantity of pus, containing actinomycetes. It was the opinion of Dr. Belfield that this patient is the subject of actinomycosis.

DR. BELFIELD said that he had been informally requested by the President to examine the case presented by Dr. Ochsner, and had found the patient exactly as described. He thought there was no question about the genuineness of the specimens exhibited. The diagnosis rested altogether on the detection of the fungi in the sputum, because if that were absent the physical signs might be due to some other cause, but he thought the physical signs in this case were caused by the fungi in the lungs.

On motion of Dr. Tilley, fifty dollars was voted to Dr. Ochsner and two members of the society for the purpose of making a series of experiments with actinomycis.

concluding from this fact that the two morbid processes were specifically distinct, but, at the same time, while admitting the hypothesis of a common origin, for the present, for these two affections, its activity was considerably attenuated in scrofula. With this idea, it was interesting to find out whether it was possible to augment the virulence of scrofulosis to such an extent as to enable it to effect the rabbit and guinea-pig indistinctly. The organism of the guinea pig is a soil extremely favorable to tuberculosis and scrofula. The latter invades its economy with such facility, and assumes such malignity, that the author was induced to inquire whether, by inoculating it through several generations, in the guinea-pig, he might be able to increase its activity enough to overcome the resistance offered to its invasion in the organism of the rabbit.

The experiments prosecuted in this direction by Dr. Arloing showed that the passage of scrofulosis in the guinea-pig, during two successive generations, does not augment the virulence for the rabbit, nor does it modify sensibly that which it possessed for the guinea-pig. The result would be different with true tuberculosis under its attenuated forms. Among the osseous and the articular affections of human beings known as local or surgical tuberculosis, some are beyond the resources of art, while others are considerably improved, if not cured, by the intervention of the surgeon. The latter are, according to the author, always manifestations of scrofulosis, the former are those of tuberculosis, but of a milder virulence than tuberculosis of the lungs or of serous membranes. If rabbits and guinea-pigs be simultaneously inoculated with material drawn from lesions of this nature, it may happen that the guinea-pigs present the classical alterations of generalized tuberculosis, whereas the rabbits escape with a little localized suppuration. But if the tubercles developed in the guinea-pigs be inoculated in other rabbits, the latter almost invariably contract pulmonary tuberculosis. Sometimes it is necessary to have two successive cultures to attain this result. This fact, concludes Dr. Arloing, deserves to be taken into serious consideration, as at present there is such a tendency to confound tuberculosis and scrofula in one single affection. It justifies once more the difference that the author had experimentally established between these two morbid conditions. If it is not yet proven that they are the work of distinct viruses, if it must be admitted that they are derived from one single agent, the tubercular bacillus at different degrees of activity, it must be accorded that, in true glandular scrofulosis, it is further from its primary virulence than in local tuberculosis.

Iodol may be applied in different forms, in powder, in solution, or with gauze soaked in the latter. The solution preferred till now is prepared by dissolving one part of iodol in sixteen parts of alcohol and adding to this thirty-four parts of glycerine. According to Dr. Ferrand, of Montpellier, this preparation is found useful in all cases of deep abscesses, fistulae, or wounds of cavities. In the treatment of affections of the eye, the author recommends preferably the use of the powder of iodol mixed with some

FOREIGN CORRESPONDENCE

LETTER FROM PARIS.

(FROM OUR OWN CORRESPONDENT.)

Relation of Tuberculosis and Scrofula—Iodol; in Abscesses; in Eye Diseases; Internally—Collyrium for Strabismus.

The question of the identity or non-identity of tuberculosis and scrofula has long been a mooted point in the profession, some pathologists considering them as two distinct morbid conditions, while others confound them in one and the same affection. Dr. Arloing, a well-known experimental biologist, in a communication lately made by him to the Academy of Sciences, somewhat elucidated the subject, but, it still remains open as to whether the two affections in question have the same origin or not. In a note addressed to the Academy about two years ago, Dr. Arloing endeavored to show by experimental researches that he had prosecuted with guinea-pigs and rabbits, that while these animals were susceptible of being infected with pulmonary tuberculosis, true glandular scrofula did not cause any visceral lesions in the latter. He did not, however, feel justified in