deaths; at 4 years, 4 deaths ensued, that is 13 instances in which the disease terminated fatally below the 5th year of life. Between the 5th and 9th year 11 cases of death are on record for the period in question; from the 10th to the 14th year of life, I came across 17 recorded instances; and from the 15th to the close of the 19th year, the mortality from this affection amounted to 38. The total mortality from diabetes in infancy and early adolescence, being 79, forms about 4.25 per cent. of the total deaths from this disease during this period of 11 years. Of these 79 cases, 55, which is over 70 per cent., occurred between the ages of 10 and 19. The period of puberty seems to be without potent influence upon the production of diabetes mellitus or upon its fatal termination.

Of the 13 instances of death following the affection which occurred under 5 years of age, but 3 took place in females. Among the 66 other instances of deaths from diabetes in early life 33 ensued in males and 33 in females, exactly 50 per cent. in each sex. The external conditions of life in the United States as a general rule are in the mean the same for both sexes to the 20th year; a fact to which the equal distribution of the disease in both sexes may be well ascribed.

MORTALITY FROM DIABETES MELLITUS AMONG THE COLORED POPULATION OF NEW YORK CITY, 1889-99.

In the official records I find but 15 deaths from diabetes which as designated occurred among the colored population of New York City for the past 11 years.

I could not obtain exact figures of the colored population of each year comprised in the period in question, but it seems that the death-rate from this disease in the colored race, compared with that of the white population, is exceedingly low. This may be due, to either the infrequency in which the pathologic condition appears in the Ethiopian race, or to its occasional non-recognition when it is present. The great majority of the colored people belong to the lower strata of the populace, to that class which get along with a home-made diagnosis of its ailment or frequent dispensaries or "cheap" doctors. Thus it might happen, that the real disease is not infrequently overlooked and that the patient treats himself or is treated for another affection.

Of the 15 specified instances, 9 deaths occurred in males and 6 in females—a proportion divergent widely from that occurring in the white population.

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CUTANEOUS DISEASES ACCOMPANYING DIABETES.*

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In this paper I shall consider those cutaneous diseases which occur with more or less frequency in diabetes, many of which are extremely annoying and painful, others dangerous, contributing in no small measure to the fatal issue of the disease. The recognition of the causal relationship existing between these eruptions and the glycosuria is an absolute prerequisite to the successful treatment of the former; and, as in many instances they are the first noticeable symptoms of diabetes, they also possess distinct value in the diagnosis

of this affection. The greater number of them are of an inflammatory character, resembling in a general way the inflammatory diseases of the skin due to other causes, but also presenting certain peculiarities as to location and course, which suggest their etiology. A few are so constantly associated with sugar in the urine that they deserve the name "diabétides," first proposed by Fournier to indicate cutaneous diseases peculiar to those suffering from diabetes.

When the glycosuria is accompanied by excretion of large quantities of urine and likewise in the late stages of the malady, the skin is apt to be extremely dry, owing to the great diminution in the quantity of perspiration and sebum excreted, and a constant desquamation of fine white scales goes on; the hair too, becomes thin, dry and lusterless. This abnormal dryness of the skin is usually accompanied by a more or less marked general pruritus. The nails of the fingers and toes are likewise apt to present various abnormalities. They are unusually brittle and devoid of their normal luster; and in exceptional cases some or all of them are lost. This fall of the nails may be preceded by evident disease, or it may occur without precedent alteration of the nail-structure. Hemorrhage may take place into the nail-substance and trophic changes leading to deformity may occur as the secondary consequences of a diabetic neuritis. Intense pruritus localized about the vulva in women, the scrotum in men, the perineum, anus, and inner surface of the thighs in both sexes, is an extremely common symptom of diabetes; indeed so frequent is this form of pruritus that its presence should invariably lead to an examination of the urine for sugar. The itching in this form of pruritus is almost unbearable, and the violent scratching and rubbing to which the patient is irresistibly impelled leads in most cases to the development of an eczema.

Various forms of erythema may occur; the commonest are symmetrical patches situated on the face and a papular variety met with usually in young subjects, consisting of split-pea-sized, pinkish, slightly elevated lesions, situated on the forearms and legs; these papules may coalesce after a time to form variously sized patches.

Urticaria of a chronic type is likewise met with in a certain proportion of cases, due either to the direct irritation of the skin by the sugar present in the circulation, or resulting from disturbances in the alimentary canal.

One of the commonest and most distressing cutaneous complications of diabetes is eczema, situated most frequently about the genitalia, especially in women. This may begin as a severe pruritus, no evidences of inflammation being at first visible, but presently the skin becomes inflamed, partly from the violent scratching to which the parts are subjected, partly from the irritation produced by various micro-organisms—*torula cerevisiæ*, etc.—whose growth is favored by the saccharine urine with which the parts are apt to be frequently soiled. In many instances the affection is eczematous from the beginning; the skin is a bright-red, and oozes a sticky serum which soon dries into thick crusts. The inflammation may be limited to the genitalia, but more commonly it spreads up over the abdomen and down over the thighs, oftentimes involving a considerable area. In many cases this eczema presents nothing peculiar except its localization; but it may assume a very acute erythematous form which runs a rapid course, a form regarded by some authors as characteristic of diabetes. In men the prepuce is often the seat of an eczematous inflammation of a very severe grade, which produces marked thickening and narrowing of the preputial ori-

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fice, with the formation of exceedingly painful fissures about its margin, leading in some cases to an extreme degree of phimosis. Balano-posthitis usually accompanies this condition of the prepuce, due to the retention of small quantities of saccharine urine after each act of micturition and the decomposition of the sebaceous material so abundantly excreted in this region. It is worth while bearing in mind that pruritus or eczema about the genitalia may be the first symptom of diabetes, occurring in patients who suffer neither from excessive thirst nor polyuria.

In elderly subjects and in the later stages of diabetes a severe form of acne—acne cachecticorum—may occur, due largely, no doubt, to the extreme malnutrition of the skin. In the same class of patients painful furuncles, occurring singly or, what is more common, in crops, and carbuncles, are common events; it is estimated that about one-third of all such affections are due to glycosuria. Carbuncle, besides being an extremely painful and exhausting affection, is often of very grave import, being in many cases the direct cause of the patient's death. The frequency of such local affections is probably due to the unusually favorable conditions offered by the sugar-saturated tissue for the growth of pyogenic micro-organisms. In their clinical features these furuncles and carbuncles do not differ from similar lesions occurring in the non-diabetic; therefore their occurrence should always suggest the possibility of their glycosuric origin, and lead to an examination of the urine.

As papillomatosis diabetica, Kaposi has described an unusual affection characterized by the sudden appearance of an inflammatory patch on the back of the hand which suppurated and was followed by ulceration. At the site of this ulcerating lesion numerous papillary outgrowths, partly red and oozing, and partly horny, were formed. The patient had suffered from saccharine diabetes for twenty years.

A much more serious complication than any of those already mentioned, is gangrene of the skin. This may exist as moist or dry gangrene, usually in single, but sometimes in multiple, lesions; it may be limited to the skin and subcutaneous tissues or it may involve the deeper structures, even affecting an entire extremity. In rare cases it occurs symmetrically on the extremities, and is then suggestive of Raynaud's disease; but the absence of the peculiar train of symptoms which precedes by some considerable time the death of the skin in this affection—local ischemia and asphyxia—will usually suffice to exclude it. Under the name of bullous serpiginous gangrene, Kaposi has described a rare form of diabetic dermatosis in which the death of the skin is preceded by a bullous eruption, the subsequent gangrene extending serpigiously. In diabetics gangrene of the skin may follow the most insignificant injury, or it may be the result of some one of the many inflammatory affections so common in this malady. It may even occur without any precedent injury or inflammation, and is then probably the result of a neuritis or changes in the vessels supplying the part.

One of the most characteristic eruptions of diabetes is that known under the name of xanthoma diabeticorum. Although it is said to occur in rare instances without glycosuria, yet sugar is found in the urine in so large a proportion of the cases that it may be regarded as almost pathognomonic of diabetes mellitus. The eruption is usually moderate in extent, affects by choice the elbows, knees, and buttocks, and consists of yellowish or yellowish-red, rather flat papules. A moderate degree

of itching and stinging usually accompanies it. It appears somewhat abruptly, and lasts for a period varying from a few weeks to several months, or even years.

Certain other diseases of the skin may be mentioned which are occasionally associated with glycosuria, but in which the causal relationship of the latter has not yet been satisfactorily established.

Nagelschmidt has found glycosuria so often in psoriatic patients that he is of the opinion that some causal connection exists between psoriasis and diabetes; but this seems doubtful in view of the fact that in the vast majority of cases of the former affection no sugar is present in the urine. Glycosuria has also been found in a certain number of cases of dermatitis herpetiformis, but whether this is the cause or effect, or whether the association was only accidental, yet remains to be determined. In rare instances abnormal deposits of pigment take place in the skin, as in so-called bronze diabetes.

Purpura is also an occasional complication, occurring usually in the early stages, but it may also appear in the later stages of the malady, when it is probably the result of the dyscrasia often existing at this time. This complication, when of the hemorrhagic variety, may be the immediate cause of death.

A few words as to the treatment of these various affections of the skin must suffice. The local treatment is largely that of similar diseases occurring in the non-diabetic. In the inflammations so common about the genitalia scrupulous cleanliness will go far toward a cure, or if not a cure, relief. Indeed if the parts are frequently bathed before inflammatory symptoms have actually appeared, they may be entirely prevented, since, as has already been said, they are in large part due to the direct irritant effects of the saccharine urine on the skin. But the treatment of the underlying cause, the diabetes, is of far more importance than any local remedies. In many cases of genital eczema or pruritus which have obstinately resisted all local treatment, the distressing symptoms will rapidly disappear when the patient's diet is regulated so as to exclude sugars and starches.

DISCUSSION ON PAPERS OF DRS. HERRICK, STERN AND HARTZELL.

DR. S. SOLIS-COHEN, Philadelphia—The only way to avoid missing cases of glycosuria is to examine, as a routine measure, the urine of every patient, no matter how trivial his complaint appears to be. I have often found sugar in urine of low specific gravity. Every case of glycosuria, however, is no more diabetes than every case of albuminuria is Bright's disease, or nephritis. The time is coming when we shall recognize the varieties of morbid constitution of the urine as symptoms of various pathological conditions due to various etiological factors. It is true that the vast majority of cases of glycosuria are due to diabetes, yet there are many other conditions in which I do not refer merely to alimentary glycosuria, but to pathologic glycosuria apart from diet. We may find it in influenza, in malaria, and in convalescence from these affections. It is not uncommon in Graves' disease or in acromegaly. It may be intermittent or recurrent. I have seen a few cases confirming the opinions of text-books that bilateral sciatica may be due to diabetes. In every such case the urine should be examined before this condition is excluded.

DR. JAMES J. WALSH, New York City—I should like to call attention to the fact that certain diseases that were formerly considered to be rare are in reality frequent. One man in Washington has seen over one hundred cases of pernicious anemia. Dr. Stern has referred to the increase of diabetes, showing that the disease is now recognized oftener than it was. It is interesting to note that many patients die of tuberculosis, or of nephritis, without suspecting the presence of any diabetes. It is a well-known fact that about one-half of all cases that die of diabetes have some tuberculosis of the lungs at the time

of their deaths. Practically all cases of diabetes have a certain amount of albumin and casts in the urine.

DR. JOHN J. MORRISSEY, New York City—In the consideration of diabetes there is one factor in the treatment of great prominence, that is, we should treat the diabetic and not the diabetes. Diabetes is produced by many causes. In examining the connection between tuberculosis and diabetes during the past year I found, among 100 cases examined, that glycosuria was present in 30 per cent. at least. Since then I have examined 50 other cases and found it present in 10 per cent. of the cases. Where we find skin diseases of a chronic character we should, as ordinary routine practice, examine the urine, particularly when we meet with furuncles or carbuncles. The medical treatment of the latter will prove slow and unsatisfactory when depending upon a diabetic causation unless the disease be treated. I do not believe that alimentary glycosuria ever develops into true diabetes; one is merely a symptom of dietetic disturbance, the other a disease of grave importance. Each case must be individualized. No restricted diet will be found adapted for all cases. The prognosis, when the disease is due to a dietetic factor, is good. In cases which have their origin in cerebral disease, and also in the involvement of the pancreas, the prognosis is always very grave. When impotency is found associated with diabetes, it may be that both arise from the same cause, and not as a sequence.

So far as the treatment of diabetes is concerned, it is in a very chaotic condition. After using strontium and the other preparations provided by the genial manufacturer, I find that it is best to rely upon opium or one of its various preparations.

DR. C. F. WAHRER, Ft. Madison, Iowa—It is easier to make a diagnosis of diabetes now than it was formerly. Indeed, a physician possessed of an average degree of intelligence can diagnose from 80 to 90 per cent. of all cases of diabetes. In speaking of the diagnosis it reminds me of a German friend who said: "I would rather make a diagnosis and have the patient die than to have the man survive and be unable to make a diagnosis." Of course, this is what interests the physician; but it does not interest the patient. I stand up here to make a plea for the patient. In dieting these patients by any rule of thumb that rigidly forbids all sugars and starches, and feeds them on meats and certain vegetables alone, on gluten biscuits, saccharin, glycerin, and a lot of other stuff that would ruin the digestion of a sound man, we do ourselves great injustice, and the patient a great wrong, even though we limit the excretion of sugar by this diet list. We by no means modify the real disease process; we but change the symptoms, we lessen the excretion of sugar—a mere symptom—and we increase the discomfort and misery of our patients. Just picture them for five to ten years existing on a diet that no well man could live on. to say nothing of the morbid cravings of one so sick as a diabetic. The rank and file of diabetics, especially the young, die despite all treatment and dieting. The differential of the sugar eliminated by the urine will not make up for any loss in the molecular changes going on in the nervous system. Let us first know our pathology before we follow rigid rules of treatment and dieting.

DR. A. E. ROUSSEL, Philadelphia—I think all agree that the diagnosis of diabetes presents no difficulty. We occasionally meet with a case which has been diagnosed as such that afterward proves to be merely a symptomatic exhibition of sugar in the urine. At the last meeting of the ASSOCIATION in Philadelphia, I reported the case of a patient who had been treated for nearly six years. The conditions presented by the patient after being placed in the hospital led us to believe it to be an undeveloped case of myxedema. Photographs were exhibited showing the results of the thyroid treatment; the patient resumed apparently the normal condition and the sugar entirely disappeared and continued in abeyance as long as the thyroid treatment was kept up. The treatment was discontinued for one year with a return of the myxedematous symptoms and the exhibition of large quantities of sugar in the urine. This goes to show that it is possible for cases of myxedema to have sugar in the urine, as has been recorded by several observers.

In regard to the question of diet I disagree with the last

speaker regarding the fixed and fast rules in the average diet for the patient. No fixed and fast rules can be laid down for diet. The exhibition of diacetic acid, or oxybutyric acid, or of a large amount of acetone should be regarded as a danger signal of the approach of diabetic coma, and no matter what form of diet is in use it should be immediately changed for some other. Consequently the recognition of the above in the examination of the urine is to my mind more important than even the percentage of sugar present.

DR. O. T. OSBURN, New Haven, Conn.—I think we should endeavor to get at this disease from an etiological standpoint. We know that 50 per cent. of the cases of diabetes show pancreatic disease; the other 50 per cent. may not show such a condition. We know that certain nervous diseases may produce diabetes; we know that myxedema and also exophthalmic goiter may produce diabetes. Again, as Dr. Stern has shown from the statistics given, at the time of the menopause, the woman seems to have diabetes. Sugar may appear in the urine in acromegaly and in thyroid disease, etc. These cases are interesting in that they show that we may get at the source of the trouble later. It also emphasizes the fact that it is objectionable to treat true diabetics with a strict dietetic course. It is certainly true that if we take away the carbohydrates we should substitute fats.

DR. JAMES B. HERRICK, Chicago—I was interested in the statements made by Dr. Stern in reference to the infrequency of diabetes in the colored race; it bears out the experience of physicians who have practiced among the black people. Possibly it may have something to do with their manner of living. I believe that it is Von Noorden who quotes the statement that among the upper 10,000 in Berlin there were more cases of diabetes than among the lower 100,000. I am sure that those who are in hospital work, and in private practice have been struck with the greater frequency with which we meet these cases in private practice than in hospitals. Diabetes is one of the rarest diseases to be met with in the public hospitals; yet in private practice the percentage of cases of diabetes met with is rather high. So it would seem that the manner of living has much to do with it; it is much more frequent among the higher than the lower classes.

Of course, I agree with Dr. Cohen that every case of glycosuria is not diabetes; I referred to that in my paper. Certainly there is a transient glycosuria that may occur from a variety of causes. There is an alimentary glycosuria and none will insist that it is a true diabetes. But we should here utter a word of caution in regard to going too far in that direction. While we believe that there is such a thing as a functional or non-organic albuminuria, still we know what great danger there is to our patients if we do not regard all these cases with suspicion; they may be forerunners or the beginnings of organic disease of the kidneys. And in a similar way we should be cautious in declaring that a given case is one of functional glycosuria. We should be on the look-out for genuine diabetes. In many of the milder forms of diabetes there may be a temporary disappearance of the glycosuria.

Dr. Cohen has referred to bilateral sciatica. In a part of my paper that I did not read I made mention of this complication. I have always looked out for bilateral sciatica in every instance of diabetes, but I have never yet seen a single case, although I know it is referred to by many writers. Dr. Walsh very properly calls attention to the importance of testing for sugar in the urine in cases of tuberculosis.

In regard to treatment, although not touched upon by the essayists, I wish to array myself on the side of the gentleman from Iowa, as against the indiscriminate and too vigorous enforcement of diet. We should take a more liberal view of the diet question, and this is in accord with the best writers upon, and the best observers of, diabetes. If we cut our patients off absolutely from carbohydrates there is great danger of coma supervening, which may come on rapidly. I also agree with the statement that we should not treat the diabetes, but the patient himself.

DR. HEINRICH STERN, New York City—In response to Dr. Herrick's statement that diabetes, as is the general opinion, is a disease of the well-to-do, I would like to state, that in my re-

searches of the original death certificates in the city of New York, almost 70 per cent. of deaths occurred in tenement houses, a tenement house being a dwelling structure occupied by more than two families: 15 per cent. occurred in hospital practice and coroner's cases, and only about 15 per cent. in private houses. This tends to show that the malady, if it may be called such, has virtually little to do with high living. At the same time, my statistics show that the Jews have not diabetes as frequently as supposed, and that the Irish, on the other hand, seem to be those who have a larger mortality from diabetes mellitus. Possibly a Jew will take better care of himself, but it seems highly probable that alcohol is a very potent factor, indeed, in the production of diabetes.

Diabetes mellitus, as I have pointed out long ago, is not a disease per se, but merely a syndrome, merely a stage in the diabetic deterioration. I have recognized, in some instances even 2 or 3 years before the appearance of dextrose in the urine, that diabetes will occur. I divide the diabetic deterioration into three stages; 1, the preglycosuric stage; 2, the glycosuric stage, the diabetes mellitus of to-day; 3, the post-glycosuric stage, the toxemia, when acetone, acetone-acetic acid and levorotatory oxybutyric acid are present, and when the output of sugar has markedly diminished or entirely ceased.

Diabetes mellitus, or the diabetic deterioration, is a plasmolysis, and as such is not difficult to diagnose. It has nothing at all to do with glycosuria, glycosuria being merely a symptom of it, just as it is a symptom accompanying a great number of operations. I have seen glycosuria following simple chloroform anesthesia; I have seen it in the wake of the extirpation of tonsils and of the kidney: I have seen it occur after overeating, after indigestion and after headache.

The identification of dextrose is not an easy matter. It is for the chemist, not for the general practitioner of medicine. The copper tests should be abandoned altogether—Haynes', Elliott's, Fehling's, Trommer's Salkowski's—they all serve a purpose, but do a great deal of harm in the hands of the family physician.

Now, as the diabetic deterioration is a plasmolysis, how do we recognize it. I have showed some years since, that albumin may be split up into a sugar molecule on the one hand, and carbamid, or as it is wrongly called "urea," on the other. Carbamid plus glucose, or dextrose or whatever sugar of the series $C_6H_{12}O_6$ it may be, makes up albumin. In other words, I recognize the diabetic deterioration by the continued large output of carbamid + glucose; or in other words, if the egested nitrogen exceeds for any length of time the ingested nitrogen, and if at the same time sugar is excreted by the urine, then, and only then can we speak of a diabetic deterioration; then, and only then, diabetes mellitus, of the authors of to-day, is present.

I hesitate not for a moment to state that levorotatory oxybutyric acid and the fatal coma diabeticum are often the result of a too long continued rigid fat-meat diet. Coma associated with diabetes, however, is not necessarily diabetic coma. In all instances where an accompanying or intercurrent disease, like many of the chemical affections, as phthisis pneumonia, end in coma, and when diabetes is present we can not speak of a coma diabeticum. Coma following nephritic conditions, which are associated with glycosuria or diabetes, is by no means a true diabetic coma. This is only present when diabetes is unaccompanied by other chronic diseases, and when the coma shows the characteristic dyspneic feature. This dyspneic phenomenon, or Kussmaul's breathing, is the only characteristic symptom of true coma diabeticum. Without it, we have no right to term a coma, a diabetic coma; a coma accompanying diabetes is not necessarily a diabetic coma.

Injuries After Intubation.—A writer in the *Corr. f. Schw. Aerzte*, found more or less serious lesions of the mucous membrane in 11 out of 96 intubated patients. The subglottic portion of the larynx and the mucosa of the anterior wall of the trachea were most frequently the site of the lesion. The tubes used are usually too large, he thinks. When it is difficult to introduce the tube, the obstruction is usually edema and not spasm of the glottis.

POST-ANESTHETIC PARALYSES.*

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Paralyses following an anesthetic which are due to that agent alone are more imagined than real. Were it not for those unfamiliar with the recent literature on the subject it would seem an imposition to burden the profession to enter further into the discussion. "Anesthesia paralysis," post-operative paralysis," etc., still in use, foster erroneous conclusions and should be dispensed with.

It is well known to neurologists that in many alcoholics, or other drug habitués, the vulnerability of a nerve trunk is so increased that a very moderate degree of pressure over it will produce a tingling or numbness, and slight injuries may even invite a neuritis.

However, we could not seriously consider an acute toxemia as an etiological factor diminishing the resistance of peripheral nerves, rendering them more susceptible to a peripheral palsy as a sequence of general anesthesia.

Seldom have I seen a post-anesthetic paralysis that did not clear up rapidly. Usually the paralysis is due to a lesion of the nerve trunk, the so-called peripheral or pressure type. In looking up the literature I find that there is little credence given to the anesthetic as the real cause.

Mally and Leszynsky, who have given as much light on the subject as any others, classify them as central, hysterical, reflex and peripheral. These paralyses are preventable in every case, and the serious attention of the surgeon should be directed toward suitable precautions as to position, etc., during anesthesia.

The central paralyses are, as a rule, immediate and are due usually to apoplexy. Since a very large number of persons who go under an operation are, by reason of age and vascular atheroma, predisposed to a stroke even from the most trifling causes, it is not unreasonable to suppose that such an accident would be a common occurrence. It is a fact, however, that apoplexy during anesthesia is so rare that it may be considered purely accidental and in no way connected with the anesthetic.

A hysterical paralysis is just as likely to be produced by other agents than anesthesia; in fact it is so rarely post-anesthetic that it may be considered accidental and due to the moral shock rather than to the anesthetic.

Reflex palsies are so extremely rare that those best competent to judge look upon them as purely accidental.

Arms brings us up to the peripheral palsy, which is the only one of importance to the anesthetist. That oftenest seen is paralysis of the brachial plexus, caused by elevation of the arms. This elevation—Trendelenburg position—puts the roots of the plexus, especially the upper roots, at a sharp angle with the transverse vertebral processes, the indirect pressure causing the paralysis. The upper roots suffer oftenest, as the angle is more acute than that of the lower. The most frequently involved is the deltoid muscle, although other muscles, infra-spinatus and supra-spinatus, have been paralyzed; also the radial, tibial and others, no doubt from a faulty

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