causes nausea and vomiting. It is useless to try to remedy this condition in these patients while continuing to give this drug. Counter irritation over the stomach is a simple but useful procedure.

This covers the symptomatic treatment of lobar pneumonia. In the treatment of this disease, I have not mentioned venesection and arterial sedatives because their field of application is so limited as to make it a rare chance for the physician to use either to the betterment of his patient. Certainly the average patient when seen by the physician has passed the time for venesection, or arterial sedation. I will admit that there is a pre-pneumonic stage in which these measures will prevent the patient from contracting pneumonia. This is in no sense of the word an abortion, for how can any condition be aborted when it does not exist? The cases that are suited to these measures are found in strong robust persons. If the pulmonary congestion is not relieved in twelve hours, and the symptoms of pneumonia supervene, all depressing measures should be discontinued and an expectant, stimulating plan adopted.

SPECIFIC TREATMENT.

Various drugs have been advocated as specifics in pneumonia, but all of them have had an early death. Chief among these are digitalis, as advocated by Petresco, who recommends the giving of 180 grains a day and claims a mortality of a little over 2 per cent. This treatment has not met with favor. Salicylic acid has been highly lauded, but has failed to establish the claims made for it. This is not surprising when we remember that this drug depresses the heart and irritates the kidneys and digestive tract. Of late creosote carbonate has been claimed as a curative agent in this disease. It certainly benefits the accompanying bronchitis and seems to modify the infection, but after a careful trial in the Pennsylvania Hospital by Drs. Scott and Montgomery, the most that they can say for it is that experiments with it should continue with increased dosage. Iodid of potassium has very lately appeared on the field. It is said to be a specific in doses ranging from 1,500 to 3,000 grains daily. Any one who can believe this should try it. The internal administration of antiseptics has been tried with poor success. Sepine has obtained good results by injecting very dilute solutions of mercuric chlorid directly into the inflamed lung. Antipneumococci serum has disappointed the profession at large, as Dr. Welsh has shown that the antitoxin is not only absent from the blood at the time of and after the crisis, but that the toxin is actually stronger then than at any other time. So we are forced to believe Dr. Osler when he says that we have no specific for pneumonia.

Perhaps the nearest approach to a specific treatment of pneumonia is the hypodermic injection of quinin. This treatment receives the endorsement of no less an authority than Nothnagel. Muriate quinin $7\frac{1}{2}$ grs. are dissolved in $\frac{1}{2}$ ounce of sterile water. This is injected once daily into the lateral parts of the abdomen, where the cellular tissue is loose. Generally two or three injections suffice. The effect on the temperature is less than that on the general condition. It gives one the impression that the subcutaneous administration of quinin lessens the effect of the products of the bacteria which have found their way into the blood current. This treatment is worthy of a very careful trial.

Pneumonia is an infectious disease, and as such every precaution should be taken to prevent its spread. Not long ago a small house epidemic of this disease was reported from the Episcopal Hospital of Philadelphia.

The sputum should be cared for, all bed clothing sterilized, and the patient isolated. After the patient is discharged the room should be disinfected. There is no reason why pneumonia should not be included in the diseases that are to be reported to the board of health.

DYSPEPSIA IN ELDERLY INDIVIDUALS.*

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A large number—I had almost said the largest number—of our errors are those of omission. It is of a very common error of omission that I wish to speak.

Optimism is ordinarily a virtue, but when carried too far it becomes failing. It is characteristic of most of us in the consideration of the various possibilities surrounding the complaining individual who consults us that we give first thought to the minor ailments which he may have and in a falsely optimistic manner leave from our consideration all thought of the graver diseases. Reflection will, I am sure, convince any one of the fallacy of this mental attitude; for where there are conditions making possible any of several disorders certainly we should endeavor, first of all, to exclude by all the means of our power the most serious of these, and then take into consideration the least serious.

In passing, I might suggest that were pulmonary tuberculosis the first instead of the last possibility considered in the case of every youthful individual with a cough and a record of lost weight, the mortality from this disease would be lessened. We can best serve the patient in such doubtful cases not by holding tuberculosis a dreadful thought to be put behind us and not to be mentioned, but, on the other hand, by tactfully but plainly making such provisional diagnosis as will give him opportunity to take those steps which would in its incipency lead to the healing of a tuberculous process.

Somewhat similar, and this is the error alluded to above, is our mental attitude toward the elderly patient who for the first time suffers from indigestion, or who late in life begins to have acute exacerbations of an old but previously mild dyspepsia. Such a patient may have cirrhosis of the liver—he may have chronic interstitial nephritis—but he may also have, and to this possibility I ask your especial attention, cancer of the stomach.

Exactly why cancer of the stomach is a probability in these cases it is difficult to say; but experience teaches us that such is the case. Ordinary indigestion is almost always due to some faulty habit of diet, the quality or quantity of the food or else the manner of taking it is wrong. Such habits are acquired in youth or early adult life, and the resulting dyspepsia quickly follows. The person who has passed through the toils and stress of early adult life and has by hygienic living preserved his digestion will not late in life change these good habits. Advancing age carries with it many notable diseases and disorders of function, but disorders of digestion *per se* are not among them; so that the individual who has reached advanced or middle age without experiencing the discomforts of dyspepsia is not likely to do so unless some remote disease to which his age renders him liable becomes responsible.

These cases of dyspepsia in elderly individuals are naturally first seen by the family physician and on him

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lies the burden of omitting nothing in his consideration of the various possibilities. In hospital and consultation practice we do not usually see them until the condition has lasted some time and considerable progress of the disease has rendered cancer of the stomach a probability even to the casual observer. Then little can be done for the sufferer, although much might have been done a few months earlier.

As has been very aptly suggested, we have been educated up to the point of thinking immediately of cancer of the uterus when a woman who has passed a menopause bleeds from that organ; so why not give to the stomach the same consideration when, previously healthy, it begins in old age to show signs of disease.

Examples are common and I mention the following merely by way of illustration:

CASE 1 (Hosp. No. 7463).—M. H., laborer, age 43. Symptoms of dyspepsia, bad taste in the mouth, discomfort after eating, anorexia and belching first appeared seven months before admission to the hospital. He had been during this time treated by his family physician for dyspepsia. Diagnosis of cancer of the stomach was made soon after admission and he was operated on. On opening the abdomen it was seen that, in addition to the primary growth at the pylorus, metastatic carcinomata were present in the liver and the pancreas. Death occurred a short time later.

CASE 2 (Hosp. No. 8978).—A. B., boiler fireman, age 44. Patient was admitted complaining of "much trouble with the stomach." He had suffered with dyspepsia for past ten months, for which he had been treated. Physical examination revealed a tumor in the left hypochondrium and gastric analysis showed it to be a carcinoma. Operation revealed carcinoma of the pylorus. The patient left the hospital a little more comfortable than on admission, and nothing more was heard from him, but I think it safe to assume that the course of the disease was not interrupted at the late stage in which this operation was undertaken.

CASE 3.—Another case, in a man of 50 years, which made a profound impression on me, but of which, unfortunately, I have no clinical record, came under my care as an ordinary case of dyspepsia. He complained of discomfort after eating, anorexia, belching and occasional vomiting of a year's standing, for which he had been under constant treatment. I remember this man's statement, in answer to my question, that no physical examination of him had ever been made nor any attempt at determining the functioning capacity of his stomach. His clothing being removed, a tumor in the left hypochondrium was very evident, and closer examination convinced me that it was of the pylorus. Gastric analysis confirmed the diagnosis of cancer. The patient would not consider an operation, and feeling it to be hopeless, I could not urge it.

I selected these three cases for reporting because each was hopeless when it came under my care and because much could have been done for each of them had cancer of the stomach been suspected and looked for when the group of symptoms called dyspepsia first appeared.

It is not the function of this communication to discuss the means of diagnosing cancer of the stomach, which may, with the exception of a few suggestions in the recent literature, be found in any of the text-books on that subject. While there is no truly pathognomonic sign, there are conditions to be observed from an examination of the stomach contents and otherwise which, taken together, at least approach certainty in their significance. And where there is a reasonable doubt, I believe, in view of the skill attained to-day by our colleagues in surgery, that an exploratory incision is a perfectly legitimate means of diagnosis.

It seems hardly necessary to dwell on the advantages of an early diagnosis in cancer of the stomach. Many surgeons, like Czerny and Rindfleisch, state that when a recognizable tumor has appeared or marked cachexia is

present, operative measures can not accomplish anything. Yet we are agreed, and I speak as an internist, that in the earlier stages of this disease surgery can do much for the patient by increasing his comfort and prolonging life. Therefore, you can understand why I make the plea, and make it before this association of practitioners, that every middle-aged or elderly individual who for the first time has dyspepsia be studied most carefully to determine whether cancer of the stomach be present.

FIVE CASES OF MECKEL'S DIVERTICULUM.*

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In order that we may call to mind the nature of a Meckel's diverticulum, it will be necessary to recall briefly the method of development of the alimentary canal.

When the three blastodermic layers have formed a longitudinal axis and the mesoderm has partially segmented to form the celom or the body cavity, the infolding process begins from all directions, but as the embryo is by this time much elongated, approximation takes place laterly much sooner than from above and below, i. e., from headward and tailward.

Also the splanchnopleuric or inner layer approximates much more rapidly than the somatopleuric or outer layer. As a consequence of the almost complete approximation of the inner layer, the incomplete alimentary canal is formed and a narrowly constricted communication remains between it and the general vitellin cavity from which the embryo draws its nourishment until the allantois is formed. Then the vitellin cavity begins to diminish relatively very rapidly and as the outer layers close in, forming the body wall, it is again constricted at the umbilicus and divided into an extra-abdominal portion or vitellin sac proper and an intra-abdominal portion or vitellin stalk or duct, extending from the intestine to the umbilicus.

After the complete formation of the allantois, all that remains of the sac is an almost unrecognizable vestige which afterward forms a part of the umbilical cord. The duct, the intra-embryonic portion, also begins to atrophy and soon after the formation of the placenta should entirely disappear.

This disappearance, however, does not always take place and the duct may persist throughout life as a more or less patulous tube, known as Meckel's diverticulum. This is generally attached at the greatest convexity of the umbilical loop of the embryonic intestine which represents a point in the adult about three or four feet above the ileocecal junction, but may be attached anywhere from the duodenum to the cecum, or even to the rectum.

It is generally from one to four inches in length and often ends in a more or less pouched extremity, though not uncommonly it terminates in a fibrous cord several inches in length.

It is generally attached nearly opposite the mesentery and may have a mesentery of its own.

In size, it may be a mere fibrous cord throughout or as large as the intestine from which it springs, and it contains all the intestinal coats.

It is said to occur in from 1 to 2 per cent. of all individuals.

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