The following may be taken as a type formula for an extemporaneous preparation of the hypophosphites:

R. Calcii hypophosphis	
Sodii hypophosphis	
Potassii hypophosphis, āā.....	3i 4
Acidi hypophosphor.....	3i 4
Aquæ dest.....	3vi 200
Elixir q. s. ad.....	3vi 200

M. et filtra. Sig.: One or two teaspoonsful three times a day, before eating.

The elixir in this prescription may be replaced by glycerin, or an aromatic water, the combination of the hypophosphites may be varied, within reasonable limits, and the hypophosphorous acid substituted by citric acid or by an alkali citrate. When desirable sufficient bitter may be added to make the medicine more palatable or to act as a bitter tonic. For this purpose the tincture of nux vomica, or one of the bitter alkaloids, may be added.

Cod-Liver Oil.

The consideration of cod-liver oil rightly belongs under the subject of dietetics, as nearly all pharmacologists are agreed that it is merely a food, but it is so frequently lauded as a medicine that some mention of it is necessary in this place.

On the discovery of traces of certain alkaloids or ptomaines it was suggested that they possessed extraordinary value, but, as these substances are usually present in infinitesimally small quantities in good oil, and as there is no reason to suppose that they possess any beneficial effect whatsoever, it cannot be said that the so-called fat free or tasteless cod-liver oils can, in any sense of the word, represent cod-liver oil.

The crude dark-colored oil often contains a much larger proportion of free fatty acids than the white does, and it should, therefore, be more readily emulsified in the intestine and absorbed, but its disagreeable odor and taste render it peculiarly disgusting to all patients with delicate stomachs. Small doses of cod-liver oil can usually be borne, especially if it be given in the form of an emulsion, but even this is not always tolerated.

OFFICIAL PREPARATIONS OF COD LIVER OIL.

OLEUM MORRHUÆ.—U. S.—This preparation is official in some of the foreign pharmacopeias as *Oleum Jecoris Aselli*, a name that may be useful on occasions. Cod-liver oil is a fixed oil obtained from the fresh livers of *Gadus morrhua* and of other species of *Gadus*.

Average dose: 15 c.c. (4 fluidrams).

EMULSIUM OLEI MORRHUÆ.—U. S.—The emulsion of cod liver contains 50 per cent. of the oil, with mucilage and syrup, and is flavored with oil of gaultheria.

Average dose: 8 c.c. (2 fluidrams).

EMULSIUM OLEI MORRHUÆ CUM HYPOPHOSPHITIBUS.—U. S. This contains 50 per cent. of cod liver oil, 1 per cent. of calcium hypophosphite, and 0.5 per cent. each of potassium hypophosphite and of sodium hypophosphite. It is flavored with oil of gaultheria.

Average dose: 8 c.c. (2 fluidrams).

Cod-liver oil is often useful in anemias due to faulty nutrition and in the general debility which so often precedes tuberculosis. For this reason, perhaps, it has acquired a particular reputation in the treatment of tuberculosis. It can have no specific action on the bacillus of tuberculosis, nor on the course of the disease, except in so far as it is a readily assimilable food.

It is often found to be useful in rickets. The pure oil, the emulsion, or the emulsion with hypophosphites may be used, the dose to be regulated according to the capacity for assimilation of the individual case.

It may be added here that the petroleum oils alone, or in the form of emulsions, are wholly devoid of nutrient properties. They are mineral oils, and, therefore, non-saponifiable and can take no part in animal nutrition.

The Automobile's Advantages to the country physician are so manifest that I look forward, writes a Toronto physician, during the coming season to a very large increase in the motor ranks by members of the profession throughout the province of Ontario.

Clinical Reports

EXTRAGENITAL AND URETHRAL CHANCRE.

REPORT OF FIVE CASES, INCLUDING ONE WITH MULTIPLE LESIONS OF THE BREAST.*

FRANK CROZER KNOWLES, M.D.
PHILADELPHIA.

There is no phenomenon of syphilis more interesting to the general clinician than its inception in the one typical initial lesion. When this lesion has an unusual characteristic, such as prolonged incubation, extragenital location, unaccustomed appearance, particularly if of a multiform variety, our study is of even greater interest.

Before the description of these cases it might be well to give a few general statistics on extragenital and urethral chancre, in so far as they bear on this paper. Montgomery¹ states that 5.5 per cent. of his cases of syphilis were of extragenital origin, or 67 out of a total of 1,217. Bulkley² of New York gives the same percentage, 5.5 per cent., or 113 extragenital in 2,000 cases.

Fournier's³ statistics show that 6.33 per cent. of his total cases of chancre were of extragenital location. While out of 887 cases of primary syphilis occurring among women in his private practice,⁴ 45, or 5.07 per cent., of the initial lesions were extragenitally situated.

All authorities agree that the major number of extragenital lesions occur on the cephalic region, chiefly in close proximity to the mouth. According to the statistics collated by Poray Koschitz,⁵ 632 out of 852 primary extragenital lesions occurred on the head, or practically 75 per cent., and of 29 cases of the above authority in 9, or 31 per cent., the lesions were on the lips. Montgomery⁶ records slightly over 42 per cent. of his extragenital cases as occurring on the lips. According to Bulkley's² statistics, a little over 13 per cent. of his extragenital chancres were located on the finger. Multiple lesions may occur on any part of the body, most frequently on the genitalia and breast. According to Taylor,⁷ in fully one-third of all cases of syphilis occurring in women the lesions are multiple. Fournier⁸ states that 39 out of every 100 cases of primary syphilis of the breast show multiple lesions.

According to Dr. Dimey,⁹ in 206 cases of initial lesions of the breasts, one breast was affected in 132 cases, while both were involved in 74. In this last reference, which Prince A. Morrow kindly furnished me from his "System of Genito-Urinary Diseases Syphilology and Dermatology," Jullien¹⁰ has tabulated 1,773 cases of primary specific lesions compiled from the statistics of Bassereau, Fournier, Clerc and Léon le Fort. Of these chancres 89 were located at the meatus, while 17, or less than 1 per cent., were in the urethra proper. The few statistics, quoted from nine authorities both in

* Read before the Philadelphia County Medical Society.

1. Montgomery: The Journal of Cutaneous Diseases, August, 1905, p. 346.

2. Bulkley: "Syphilis of the Innocent," p. 36, Alverenza prize essay.

3. Fournier: "Les Chancres Extra-Génitaux," Paris, 1897, p. 5.

4. Fournier: Annales de Dermatol et de Syphilographie, 1887, vol. viii, No. 12, p. 757.

5. Poray Koschitz: Arch. f. Derm. u. Syph., 1890, No. 6, p. 928.

6. Montgomery: The Journal of Cutaneous Diseases, August, 1905, p. 352.

7. Robert Taylor: "Practical Treatise on Genito-Urinary and Venereal Diseases and Syphilis," 3d edition, p. 514.

8. Fournier: "Les Chancres Extra-Genitaux." Paris, 1897, p. 358.

9. Dimey: "Etude Sur le Chancre Syphilitique du Sein," Thèse de Paris, 1891.

10. Jullien: "Traité Pratique des Maladies Vénériennes" 2d edition, 1886, p. 572.

this and foreign countries, show the comparative frequency of unusually located initial lesions and teaches us to be constantly watchful that no mistake be made.

Of the following cases two were seen in the Dermatologic Clinic of Dr. Chas. N. Davis at the Pennsylvania Hospital, one in the Genitourinary Clinic of Dr. H. M. Christian at the Polyclinic Hospital, one in the Dermatologic Clinic of Dr. M. B. Hartzell at the University of Pennsylvania Hospital, and one in my own practice.

CASE 1.—Walter T., mulatto, age 26, clerk, born in Philadelphia. First seen in Surgical Dispensary of Pennsylvania Hospital on June 20, 1904. At that time he had a quarter-dollar sized, elevated, sharply marginate, fungating, crusted, slightly indurated lesion on posterior surface of right index finger, over phalangeal-metacarpal articulation. This lesion was of six days' duration. No glandular or other specific symptoms were present. The treatment consisted of mild, local, antiseptic applications. The induration of this lesion was more marked on each successive visit. On July 17 the patient returned after an absence of ten days, with a typical roseolar eruption, general glandular enlargement, pharyngitis and pains in body. The patient had been referred to the Cutaneous Clinic, after a few dressings in the surgical dispensary, where the following history was discovered: On April 18 this man engaged in a fight, hitting his opponent in the teeth, causing an abrasion at the site of the present lesion. This abrasion subsequently healed, but on June 14, or eight weeks following this injury, the present lesion appeared. The secondaries appeared precociously in four and a half weeks.

CASE 2.—C. D., an Italian girl, aged 22, married, came to the Cutaneous Clinic at the Pennsylvania Hospital on May 1, 1905, showing the following: Just below left nipple, in areolar formed by glands of Montgomery, were two dime-sized, sharply marginate, raised, markedly indurated, crusted lesions, separated by about one inch of sound skin. On the right breast one other lesion of the same character and location was seen. The duration was fifteen days. The only subjective sign was pain all over the body. No objective sign of syphilis was present. The patient was seen three times during the next ten days with no new developments except an increase in the button-like induration of the lesions and in severity of muscular and osseous pain. After an interval of almost three weeks the patient returned on June 27 with a macular eruption of one week's duration, covering the entire body and face; numerous mucous patches of lips, tongue, soft palate and tonsils were present, also general glandular enlargement and pains in entire body. Unfortunately no history was obtainable in this case. Her only child, a girl of 11 months, was apparently in perfect health, although still breast-fed.

CASE 3.—F. P., male, aged 30, came to my office May 29, 1905, complaining of a urethral discharge of ten days' duration. On examination an irreducible phimosis was found, also a profuse muco-purulent discharge. Of still greater interest, on palpating the penis, a hazelnut sized, firmly indurated, button-like mass was found one and a half inches behind the meatus, on the roof of the urethra and partially surrounding the same, this latter mass being of three weeks' duration. After cleansing the foreskin with potassium permanganate solution, the two glass test was tried, the first glass only showing cloudy urine with shreds. The only subjective sign was bilateral enlargement of inguinal glands. No primary incubation period could be determined, for the man was extremely promiscuous in his intercourse. On June 19 the patient again appeared in my office, after an absence of three weeks, with a profuse, ham colored, multifiform eruption, chiefly small, flat, papular in type, general glandular enlargement, husky voice, pharyngitis, slight thinning of hair, and generalized pains in bones and joints. These secondary symptoms appeared ten days before this present visit. No microscopic examination having been made for the diplococcus of Neisser, a superadded gonorrhea can not be positively stated.

CASE 4.—S. M., male, aged 22, came to Genitourinary Clinic at the Polyclinic Hospital on Aug. 15, 1905, with a dime sized, sharply marginate, crusted, slightly raised indurated lesion,

slightly to left of median line of lower lip. The duration was ten days. The incubation period was indefinite. There were no other signs of beginning syphilis. On September 12 the patient returned, after an absence of five weeks, with a marked pharyngitis, the post-cervical, submaxillary and inguinal glands were enlarged, and a faint macular eruption of one day's duration was on chest, abdomen and back. The generalized eruption in this case followed a secondary incubation period of just six weeks.

CASE 5.—Charles T., aged 42, blacksmith. This patient first came to the Cutaneous Clinic of the University of Pennsylvania Hospital on Feb. 23, 1906, complaining of a large swelling of the lower lip. On the vermilion of the lower lip just to the left of the median line, a quarter-dollar sized densely indurated, slightly crusted, raised, button-like lesion was found. The post-cervical and submaxillary glands were enlarged and an extragenital chancre was diagnosed. The man stated he had no eruption on the body. As in all cases, not trusting to the patient's own observation, we made the man disrobe. One glance at the patient's body was sufficient to see a generalized macular eruption over arms, legs, trunk, and a few lesions of the same character on the forehead. The throat showed a pharyngitis, with small mucous patches of post-pharyngeal arches. The exact primary or secondary incubation period, or the duration of the initial lesion and secondary eruption could not be determined. The patient stated that the lesion had appeared on the lip three weeks ago; probably twice that length of time would be nearer the truth. The macular eruption could have had a duration of but a few days. This man, being separated from his wife, was in more danger of being exposed to contagion.

Only those cases have been reported in this series in which the diagnosis was proved by the appearance of the secondary eruption and concomitant signs of syphilis.

During this same period three other cases were seen, in each of which the provisional diagnosis of extragenital chancre was made, two of these cases having indurated, single, lesions on the fingers and in one case on the upper lip. Unfortunately, as each of these patients made but the one visit, our provisional diagnosis could not be conclusively proved.

332 South Seventeenth Street.

A CASE OF PRIMARY SYPHILITIC INFECTION IN THE NOSE.*

JAMES T. CAMPBELL, M.D.

Professor of Otolaryngology and Rhinology in the Postgraduate Medical School.
CHICAGO.

Chancre of the nose is one of the rarest of lesions. Kreffing¹ gives statistics of 2,916 cases of chancres, of which 539 were instances of extragenital infection, and Salsotto² records 201 cases of extragenital chancre with no case of primary nasal infection. Bulkley³ gives a table of 9,058 cases of extragenital chancre in which primary infection of the nose occurred ninety-five times. Bosworth⁴ states that in 2,244 cases of chancre observed by Bossereau, Clerq, Lefort, Fournier and Ricord, the primary lesion was found twice in the nose. Le Bart⁵ reports thirty-seven cases of primary nasal chancre, of which twenty-one were external and sixteen within the nostril.

The earliest recorded case I can find is that of Mc-

*Read before the Chicago Laryngological and Otolaryngical Society.

1. Archiv. f. Derm. u. Syph., 1894, vol. xxvi, p. 167.

2. Sifilomi Extragenitali et Epidermie di Sifilide, Brochure, Turin, 1892.

3. Syphilis in the Innocent.

4. A Treatment on the Nose and Throat, 1889.

5. These de Paris, 1894.