without sufficient medical supervision. This disease, like any formidable enemy, requires constant watchfulness—to help gains promptly, and as promptly to stay relapses. The general practitioner himself is apt to fail in this because his attention is absorbed in critical acute cases; but he also fails to place his patients in proper medical care when he sends them away, whereas the presence of a physician skilled in treating such cases should often determine the selection of a residence for the patient.

These are a few of the more serious of the errors in dealing with cases of pulmonary tuberculosis, by means of which hundreds of lives are sacrificed which might have been saved.

Therefore it becomes us to iterate and reiterate our warnings as long as they continue to exist.

SUGGESTIONS: THE RESULT OF RECENT EXPERIENCE WITH PHTHISICAL PATIENTS.¹

BY VINCENT Y. BOWDITCH, M.D., BOSTON.

MR. PRESIDENT AND MEMBERS OF THE CLIMATOLOGICAL ASSOCIATION:—Even at the risk of being accused of “bringing coals to Newcastle” I venture to give you a few thoughts which have occurred to me of late; the result of experiences which I deem worthy of record.

Not only in my private practice but in my connection of late years with the Sharon Sanitarium for Pulmonary Diseases, at which place the express stipulation for entrance is that the cases shall be strictly in the “incipient” form in which the tubercular symptoms are *just beginning* to show themselves, I have been frequently impressed with the fact when patients have been sent for examination that one or two of what I believe to be the most important features in diagnosis, or rather prognosis, have apparently been overlooked by the physician in attendance. It has therefore seemed to me worth while to lay special emphasis upon these points at one of our meetings, hoping thereby to give that additional weight which comes from the utterances of an Association whose work is known to be in special directions.

It is a comparatively easy task to make the diagnosis of pulmonary tubercular disease even in the early stages, where the physical signs are definitely marked and the general symptoms are those so familiar to us all, but in those cases in which the signs, such as dullness upon percussion, changes in the respiratory murmur and even râles, are lacking, our powers of diagnosis and prognosis are often taxed to the utmost. It is in these latter cases that I have frequently found that the general practitioner has not paid sufficient attention to what I deem the most important symptoms, namely, the quality of the pulse, the temperature and condition of the digestive organs. Very often I have had cases sent to me as suitable for treatment with a hope of arrest of disease because of a lack of definite physical signs in the chest beyond possibly a few sparse râles or slight change in the respiratory murmur. I have been obliged, however, in these cases to give a very grave prognosis and have been unable to receive them as patients at the Sanitarium, simply because a weak, rapid pulse, more or less elevated temperature and poor condition of the stomach tell me that there is

without doubt disseminated tubercular disease, even in the lungs, which renders the case a most unfavorable one for treatment, usually showing after death the almost universal dissemination of tubercle without perhaps marked breaking down of tissue.

It has been said by some one that he would prefer to treat a patient with two bad lungs and a good stomach, than one with one bad lung and a poor stomach.

While making due allowance for the more or less sweeping character of all such epigrammatic statements it has the very element of truth which I am endeavoring to emphasize. The importance of recognizing the unfavorable character of the cases I have mentioned cannot be overestimated, for it may make all the difference in the world to the poor patient as to whether he shall under such conditions be advised to go, for instance, to Colorado or other distant health resorts, with the chance of aggravating some of his most distressing symptoms, or, better, advised to make a less radical change and remain nearer home and friends.

I feel confident that those of our members here who live in the more noted health resorts will, from their experience, support me in emphasizing the importance of recognizing these facts which affect the whole future welfare of the patient.

In a word then; a rapid, feeble pulse, fluctuating temperature, dyspnea, a pasty or dusky complexion and poor digestion are symptoms very frequently if not usually entirely inconsistent with a truly *incipient* form of pulmonary disease even when the physical signs in the chest are very few or even entirely lacking under the ordinary method of examination by auscultation and percussion.

Such symptoms moreover should militate strongly against the advice usually given for cases of true incipient phthisis, more especially against those forms of treatment which involve radical changes of climate away from home and friends.

I now wish to refer to a subject upon which I have already written a short paper, prepared for, but not read, at the meeting of this Association two years ago at Lakewood.²

A short time previous to that meeting I had been so astounded and stirred by statements made not only by laymen but by some physicians at the State House in Boston concerning the proposed abolition of two most useful institutions for consumptives in the suburbs of the city, that I felt I must protest against what seemed to me the extravagance of what was said and done at that time.

What I dwelt upon then was chiefly the fact that in our enthusiasm for the results of recent bacteriological work we are in danger sometimes of forgetting the patient's position, and in our desire to prevent spread of disease are oblivious of the fact that by sweeping, unguarded assertions, we are not only creating a spirit almost of terrorism among the friends, but are causing mental anguish to the phthisical patient himself, who feels himself a leper, a constant menace to the health and comfort of those he loves.

I cannot think, in fact know I am not alone in having instances of the unreasonable, sometimes brutal, behavior among friends of patients, founded upon an exaggerated fear, as I deem it, of the infectious nature

¹ Read at the annual meeting of American Climatological Association at Bethlehem, N. H., August 31, 1898.

² A Plea for Moderation in Our Statements Concerning the Contagiousness of Phthisis. Boston Medical and Surgical Journal, 1896.

of tubercular disease which, we have been taught, loses its chief source of danger when moderate measures are used for the prevention of infection.

Let me cite an instance: A young, sensitive girl who had undoubted symptoms of tubercular disease, enlarged glands, cough, slight expectoration containing bacilli, etc., after a prolonged stay at Sharon was enabled to return to her home and take up some light occupation. Soon after, the mother came to me in distress with the following history. She had found her daughter sitting at a table alone, very pale, with a letter upon the floor at her side. Upon asking her what was troubling her, she finally only said, "Mamma, I am a leper," and handed her the letter from a member of the family, who had formerly been very kind to her, and to whom the girl had written that she was so well now that she should soon go to see her. The mother showed me the letter and I read, "On no account whatever must you ever enter my house again; you are a source of danger to everybody." I can let you imagine the effect of such brutal words to a young, delicate girl. A subsequent letter in answer to the mother's indignant reply, said, "The highest authorities tell us this is a very infectious disease, and I must think of my child."

This is only one of many similar instances in my own practice and that of others. It may be said that the physician's function is merely to point out the truth as far as he knows it, and that he cannot control the selfishness and brutality of those with whom he comes in contact. Very true, to a certain extent, but I maintain that we are losing sight of one of the highest and noblest functions of the ideal physician if in giving our rules for the protection of the well we do not use caution in our statements founded upon recent comparatively experimental work, and fail to inculcate at the same time that spirit of kindness and thoughtfulness for the feelings of the sick which humanity demands.

I trust that I shall not be misunderstood, as I stated in my previous paper on this subject. No one could possibly feel a greater respect than I for what bacteriology has brought us already and for what is still in store for us from that source; no one could possibly feel the importance more than myself of teaching patients and their friends the paramount importance of absolute cleanliness about the phthisical patient, of the careful disposal of the sputa, and attending to the general health of those in attendance, but I maintain that this can all be wisely and kindly done without causing, as a rule, this spirit of terrorism of which I have spoken and without making such sweeping and unjustifiable statements as "all homes for consumptives are a source of danger to the surrounding community" however regulated, and other, equally to my mind, false assertions. Let us keep in mind, moreover, that in getting the "juste milieu" of every question the pendulum swings far in both directions, and the history of medicine shows us plainly that in no other profession or walk in life do we have to proceed so cautiously as in ours before finally accepting new theories, enthusiasm for which carries us at first into extreme statements which afterwards often have to be greatly modified if not entirely retracted.

Of late, we are confronted with another statement made by Flügge, of Berlin,³ regarding the possibility or probability of bacilli being carried in small droplets

of mouth fluid into the air during the act of coughing. He maintains, moreover, that the chief danger of infection comes from these suspended droplets with bacilli in them and not from the dried sputa, as we have been taught hitherto by Cornet and many others.

Up to a comparatively recent period, owing to numberless experiments by competent men, our belief has been that the expired breath has no danger unless as in violent coughing, small particles of sputa happen to be expelled, but this statement would carry us still farther and make us believe that even with the destruction of the sputa we are still exposed to what Flügge believes to be the chief source of danger.

We are in search of truth at whatever cost, and if it can be proven that Flügge's statements are based on facts, we may be obliged to change our present views, but we are justified in waiting for further proof before accepting this extreme theory.

It would seem probable, too, with the now well-known experiments of Cornet and others in Europe, and of Hance, Gardner and many others in this country upon the dust taken from rooms in Sanitaria, hotels, hospitals, etc., that the danger from spread of bacilli by these droplets in the expired breath alone must be extremely small, when it has been shown many times that in those rooms where spitting upon the floor was prohibited, and proper cleanliness enforced, the number of bacilli found in the dust was practically nothing, and again I ask for caution in accepting, still more in promulgating, this later idea with undue haste.

I ask this especially from the following fact; another illustration of the rapidity with which many of the laity seize upon a statement made by physicians, and of the state of nervous apprehension into which many are thrown thereby. Several months ago my attention was first called to Flügge's statement by a patient who came to inquire if I felt there was danger to his daughter from the cough of a young lady living not very far from his own house in the country, and of whom his daughter saw little or nothing. Except for his evident nervous anxiety it was hard to be serious in my reply that I thought that the danger amounted practically to nothing, but upon asking him why he had entertained this idea, he said he had read in one of the Board of Health Reports of a neighboring State a remark or quotation which led him to believe that there was ground for his apprehension. Later, upon reading the quotation to which he referred I found it to be the statement of Flügge which apparently the Board of Health of his State had immediately accepted and stated as a fact, a position which with our present knowledge is to my mind unjustifiable.

To hide plain, proven facts for the sake of temporary comfort I regard as wrong absolutely, but that these facts may be made known wisely and without creating terrorism and with a minimum of mental suffering to the one most concerned I believe to be perfectly possible in most cases. I speak now from the point of view of the practitioner who naturally comes in contact with these different forms of human nature more than those whose work lies in the laboratory. The practising physician can note better than any one else the dire effect of the state of nervous apprehension into which so many are thrown by fear of disease. He also sees the mental suffering given to many a poor consumptive who by the exaggeration of others has been made to feel himself an outcast, and he learns in both instances the wisdom of guarded speech.

³ Deutsch. med. Woch., October 15, 1897.

In closing, let me recall Koch's own words quoted in that most admirable essay on the "Prevention of Tuberculosis," by James B. Russell, of Glasgow, and reprinted for general circulation by the Massachusetts State Board of Health; an essay that should be read by every medical man. In fully recognizing the utterly different elements which enter into cases of phthisis as compared with other infectious diseases, he says, in the closing words of his famous treatise, "It seems to me the time has now come to adopt prophylactic measures against tuberculosis. But owing to the wide distribution of the disease, all steps taken against it have to deal with social relations, and it must be, therefore, carefully considered in what way and how far we may proceed without neutralizing, by unavoidable disturbances and other disadvantages, the benefit obtained."

To the courtesy of Dr. J. J. Curry, U. S. A., late of the Boston City Hospital Pathological Department, I am indebted for the manuscript of his paper read before the Suffolk District Society in Boston last spring, and soon to be published in the *Boston Medical and Surgical Journal*.⁴ In this he gives the results of some experiments made while associated with Prof. Edwin Klebs at Citronelle, Ala., last winter. Although granting that the number of the experiments is small, he judges from his experience thus far that although very probably bacilli are found in a certain number of the small droplets expelled from the mouth during hard coughing and that hence certain precautions are wise, yet he believes that the dangers spoken of by Flügge are greatly overestimated.

Let us be careful then in promulgating the theories of those whose work hitherto has gained our confidence and whom we regard as teachers and leaders in our profession, lest in our zeal we go much farther than they themselves intend, and in so doing injure rather than aid the object we have in view.

Clinical Department.

SCORBUTUS IN A BABY WITH HEMORRHAGIC DIATHESIS.

BY JOSHUA C. HUBBARD, A.B., M.D., BOSTON.

THROUGH the kindness of the Boston Lying-in Hospital and the Infants' Hospital I am able to report almost the whole life history of the following case:

Eva McK. was born about half-past ten in the evening of March 9, 1898. Although there was nothing remarkable about the labor the baby was cyanotic and required stimulation. The next morning at four o'clock there was oozing from the cord and right conjunctiva. A fresh ligature stopped the bleeding from the cord though only temporarily, as it began again in a few hours. Another ligature was applied. The baby was cyanotic, breathing with difficulty and appearing almost lifeless. In the evening the bleeding from the cord again started and was again checked by a fresh ligature.

March 11th. Last night the baby vomited some blood. To-day some cerebral irritation shown by twitching of the eyelids, rolling of the eyes and convulsive movements of the arms. Hands and arms are

of a yellowish tinge. In the evening convulsive movements of the head.

March 12th. During last night convulsive movements of the arms. During these attacks internal strabismus of both eyes. Baby lies with thumbs turned in, arms tightly flexed, legs crossed and whole body rigid. At times there is some retraction of the head.

March 18th. Blood appeared last night in both the vomitus and the dejections.

The baby was then transferred to the Infants' Hospital where she had no more hemorrhages. On March 30th she was transferred to the South Department as Klebs-Löffler bacilli were found in her throat on routine examination. I will quote nearly the physical examination made on entrance.

Rather emaciated. Desquamation on hands and feet especially, also on some other parts of the body. Cry not very strong. Skin of yellowish tinge mixed with red. Considerable rigidity of the extremities, especially of the arms. Elbows flexed. Impossible to fully extend them. Attempts to do so make the biceps muscle hard and its tendon prominent and rigid. The fingers are clenched tight, the thumbs in the palms. The feet cannot be extended beyond a right angle, the anterior tendons then becoming tense and showing under the skin as though they were shortened. Legs cannot be fully extended at the knees. Eyes are not abnormal externally. No rigidity of the neck. Left frontal region flattened on the vertex as compared to the right. Heart and lungs normal. Spine normal. Abdomen not examined because of dressing about cord. Excoriation about anus. No evidences of hemorrhage in the skin or mucous membranes.

Sometime in the latter part of August the baby was brought to the Out-patient Department of the Infants' Hospital with the following history:

Her food had been malted milk two drachms, water four ounces, lime-water one drachm, the water being warmed but not boiled. The baby had been doing well until two weeks previous when she began to grow sore all over, the ankles, wrists, shoulders and, a few days later, the knees swelling. Some bleeding from the bowels for the last two or three days and from the mouth on one day. No eruption had been noticed. The urine was scanty but not red. The baby was referred to the Summer Hospital where I saw her, and on August 30th made the following physical examination.

Well developed and nourished baby. Pale. Cries when moved. When quiet seems free from pain. Knees and thighs held flexed. Arms held thrown back with hands by head. Fingers and thumbs flexed. Cannot be fully extended, apparently held by the palmar fascia. Fontanelle small, not depressed. Slight umbilical hernia. Heart, lungs, liver and abdomen negative. Pupils equal. No stomatitis. Hard, non-fluctuating, tender swellings at distal ends of radii and ulnæ, sternal ends of clavicles, distal ends of femora and tibiae. Large swelling on outer posterior aspect of left leg just below the knee-joint. Marked swellings at the junctions of the ribs with their cartilages, many of them of more even form than the ordinary rosary of rickets. No enlarged glands. No increased temperature.

The baby was given modified milk, orange juice one-half ounce three times a day, and later some brandy

⁴ October 13, 1898.