Correspondence.

"Audi alteram partem."

A FOREIGN BODY IN THE STOMACH FOR SIX MONTHS.

To the Editor of THE LANCET.

SIR,—An infant of eight months old was brought to me this evening with the following story. When eight weeks old the child had swallowed an indiarubber teat; the mother gave her a dose of castor oil and watched the motions to see if the teat would pass through, but found no signs of its doing so. The child has been in good health and has not been seen by a doctor until a fortnight ago, when I saw her for a slight bronchial attack. This morning the child had breakfast of warm milk with a little bread crumbs in it and soon after vomited and in the vomit was the teat inclosed herewith. The child is a healthy-looking, well-nourished baby and seems perfectly well, so if the story is true the presence in the stomach of a large piece of vulcanised rubber has given rise to no symptoms and has not affected the child's growth or strength in any way.

I am, Sir, yours faithfully,

LAUNCELOT ARCHER.

Vincent-square, Westminster, Sept. 18th, 1908.

* * We have received the teat which is in two pieces and is stained slightly yellow.—ED. L.

THE MEDICAL DIRECTORY.

To the Editor of THE LANCET.

SIR,—May we ask for the courtesy of your columns to announce our intention of reverting in the 1909 issue to the old plan upon which the "Local List" for London was arranged, namely the division of Inner London into streets in preference to districts. We thank your correspondent "Non Edipus" and other gentlemen who have written to us for the expression of their views on this subject.

We are, Sir, yours faithfully,

J. & A. CHURCHILL.

Great Marlborough-street, London, W., Sept. 18th, 1908.

THE MEDICAL ASPECT OF GASTRO-ENTEROSTOMY, BASED ON 128 OPERATIONS AT THE MANCHESTER ROYAL INFIRMARY.

To the Editor of THE LANCET.

SIR,—It is difficult to thank Dr. Leech adequately for the temperate and judicial analysis of the cases in which gastro-enterostomy has been performed in the Manchester Royal Infirmary, published in your issue of Sept. 19th. I do not think any surgeon will feel disposed to cavil at the conclusions at which he has arrived, especially that conclusion which has reference to the disastrous consequences of delay. But there is one point telling strongly in favour of early operation which Dr. Leech has not mentioned, and which certainly deserves to be taken into consideration in weighing the merits or the demerits of this operation. There were 46 cases of malignant disease. In one of these the growth was a secondary one; in two others the situation is not mentioned. These may be left upon one side. In 40 out of 43 the growth was at the pylorus—the part of the stomach in which chronic ulcer is most common. In what proportion of these 40 cases did the growth originate at the site of an old ulcer, which had failed to heal under medical treatment and which would at least have had a chance of healing if timely gastro-enterostomy had been done?

It is notorious that in every part of the body, stomach included, carcinoma is especially prone to develop at the site of an old ulcer which is prevented from healing; and the identity of situation in such a large proportion of cases is most significant. It is not the least argument in favour of early gastro-enterostomy that, in addition to the relief it gives, it will, by enabling a chronic ulcer of the stomach to

heal more readily, diminish the frequency of gastric carcinoma.

I am, Sir, yours faithfully,

Wimpole-street, W., Sept. 20th, 1908. C. MANSELL MOULLIN.

THE PREVENTION OF TUBERCULOSIS (IRELAND) BILL.

To the Editor of THE LANCET.

SIR,—In THE LANCET of Sept. 19th, p. 901, Dr. J. C. McWalter, writing in reference to the Prevention of Tuberculosis (Ireland) Bill, says: "Knowing what I do of the Irish people, I believe that the Compulsory Notification Clauses will excite so much suspicion and dread as effectually to undo any good result heretofore obtained from the tuberculosis campaign. People simply will not go to a medical man if they think that by so doing they may be listed as tuberculous."

Now, Sir, while Dr. McWalter gives no evidence of any kind beyond his own individual opinion in support of such a prophetic view he totally ignores the following facts: 1. In places where there is compulsory notification (and here we are dealing with practical experience and not with mere theoretical opinion) no difficulty of this kind has arisen. If practical experience in Sheffield, Edinburgh, Bolton, and New York (where there are so many people from Ireland) has clearly demonstrated that there are no serious objections to compulsory notification, why should there be any in Ireland? 2. At the meetings held in connexion with the Tuberculosis Exhibition all over Ireland resolutions were passed by the people of Ireland calling upon the Government to legislate upon certain points regarded as essential and one of these was the compulsory notification of tuberculosis. Then a deputation of almost everybody who could speak with authority in Ireland on such a question waited on the Lord Lieutenant, the Chief Secretary, and the Vice-Chairman of the Department of Agriculture on Nov. 29th, 1907, asking that special legislation should be introduced without delay with the object of making it compulsory that all cases of pulmonary tuberculosis should be notified; and, finally, on August 27th, 1908, at a large conference of delegates summoned from all parts of Ireland, a resolution was carried with only two dissentients heartily approving of the principles of the Tuberculosis Prevention (Ireland) Bill and earnestly desiring to see it passed into law. Does Dr. McWalter really believe that the people who were at these meetings and on this deputation would have taken such a line of action had they for one moment imagined that the compulsory notification clauses would cause any annoyance, or that the people would object to them, or that they would impale for life persons notified? Ireland enjoys the unenviable notoriety of losing close upon 12,000 of her people every year from tuberculosis—that is, 15 per cent. of all the deaths in Ireland are from tuberculosis. Is this to continue or is she not to be allowed, if her people wish it, to take her position with those in the van in trying to get rid of a largely preventable disease?

Let us discuss this problem in a thoroughly scientific and practical way.

I am, Sir, yours faithfully,

Belfast, Sept. 21st, 1908.

JOHN BYERS.

A QUESTION OF SOBRIETY.

To the Editor of THE LANCET.

SIR,—The regret expressed by "M.D." at finding himself at variance with me seems to me uncalled for, for I cannot find anything in his account of himself or of his cousin that conflicts with the opinions I hold on the nature of drunkenness. Perhaps the account of my address, to which you courteously gave the hospitality of your columns, was so much compressed as to be obscure. A full report will appear in the October number of the *Journal of Mental Science*, and if "M.D." will do me the honour to read it there, or in a copy which I shall be happy to send him on request, I am confident that he will find his criticism unnecessary. Few people have preached, more insistently than I have, the doctrine of the inescapable responsibility of every man for his own acts; and many a trouncing have I had from my colleagues for such preachments. That I should now be accused of supporting the opposite opinion is startling, and impels me to declare that the abstract of my address was

written before dinner—and, in any case, I, like “M.D.,” am practically a teetotaler.

I am, Sir, yours, &c.,

Wimpole-street, Sept. 21st, 1908.

CHAS. MERCIER.

ON CHRONIC MORPHINISM AND ITS TREATMENT.

To the Editor of THE LANCET.

SIR,—The article which appeared in your issue of Sept. 12th on Chronic Morphinism by Professor Gamgee is highly instructive and is certainly the best contribution on that subject which I have read. Several theories have been propounded as to the cause of the distressing phenomena which follow abstinence from morphine in cases of chronic morphinism, but in my opinion Professor Gamgee's is by far the most sound. In regard to these symptoms and their treatment there are a few remarks I would like to make. During the last seven years I have treated for chronic morphinism 52 cases and therefore have some little knowledge of the subject. In regard to the symptoms that affect the nervous system I agree with Professor Gamgee, but in regard to the circulatory, respiratory, and gastro-intestinal my experience compels me to differ slightly. The intense cardiac dyspnoea which he speaks of I have not met with, except in one case where the patient had been taking 80 grains of morphine per day before coming to me, and it took six months before the drug was entirely stopped. In regard to the gastro-intestinal symptoms, nausea, vomiting, and gastro-intestinal catarrh, these I have not found common, and when they have arisen I have found no difficulty in treating them, except when the patient has been in the habit of taking the morphine by the mouth. Constipation is as a rule present while the patient is taking the drug, and this may persist for some time after the drug has been cut off; strong purgatives may have to be used whilst the patient is taking morphine, but it is unwise to give these when the morphine is stopped. Enemata and mild laxatives are safer methods, bismuth subnitrate may also be given; with careful management I have always found these symptoms disappear.

In regard to treatment Professor Gamgee designates the sudden withdrawal of the drug as the English method. I do not admit that this is the English method; it may be the method adopted by English asylums, but certainly not by the different sanatoriums or retreats which make the treatment of morphinism, narcomania, or inebriety their special branch of medicine. I myself have invariably treated chronic morphinism by the slow reduction method. Professor Gamgee gives the time of from six to ten weeks in effecting this. This as a rule is too short, the average time being 13 to 16 weeks, and I have had cases which have taken over 20 weeks before the drug was abolished so as to avoid severe suffering and mental distress. I am quite aware that there is such a thing as syringe mania, but I find it far more satisfactory to continue the use of the hypodermic syringe till the last dose is given and even afterwards, when only a saline solution is injected. Giving it by the mouth and leaving off the syringe I have found adds to my difficulties. In regard to the nervous system symptoms—(a) *Insomnia*. After the drug has been cut off there is no doubt insomnia is one of the commonest symptoms complained of by the patient. I agree with Professor Gamgee in finding veronal extremely useful but seven grains is of little use; double that dose is required as a rule to combat this symptom and this drug must be slowly reduced or else insomnia is apt to return. (b) *Uncontrollable restlessness*. This is by far the most common symptom and I think the most trying to the patient, the constant twitching of the legs or arms, or as Professor Gamgee more aptly calls it the “fidgets” in the extremities are very trying and distressing to the patient. I have used for the treatment of this with marked success a preparation containing acetanilide two grains, caffeine citras five grains, sod. bicarbonate three grains. This remedy has succeeded when everything else has failed. (c) *Maniacal and suicidal symptoms* are rare but delirium and delusions are common; these as a rule pass off with ordinary treatment.

Professor Gamgee does not lay sufficient stress on the danger of administering alcohol either when the quantity of the drug taken by the patient is being reduced or has been cut off. In my experience I find that alcohol aggravates all these symptoms, and I would like to add

that after the patient has recovered alcohol as a beverage ought to be avoided. In nearly every case in which relapse has occurred, after having been successfully treated, I find that the use of alcohol started the craving for morphine.

I quite agree with Professor Gamgee in strongly condemning any attempt to cut off the patient suffering from chronic morphinism from the drug at once. It is almost criminal treatment, and I also agree with him that these patients should only be dealt with in a place where treatment can be thoroughly carried out—that is to say, where the hygiene is good, the air bracing, a proper nursing staff kept, and the patient is under the supervision of a medical man who has made a special study and has practical experience of this subject. Professor Gamgee does not refer to the after-treatment to prevent relapse. If patients, after their chronic morphinism is cured, would remain under supervision for a considerable time, say six to 12 months, there would be fewer relapses. A long period would not only give them time to build up their physical strength and establish their general health but would also give them more brain power in resisting temptation to resume their habit.

I am, Sir, yours faithfully,

JOHN Q. DONALD, L.R.C.P., L.R.C.S. Edin.,

Colinsburgh, Fife, N.B., Sept. 17th, 1908.

TO MEDICAL FREEMASONS.

To the Editor of THE LANCET.

SIR,—May I once again, through the medium of your widely read columns, appeal to medical men, and medical Freemasons in particular, for votes for the Masonic schools? At the forthcoming elections in October there is only one medical candidate for the Royal Masonic Institution for Boys, William Henry Collins, son of William C. G. Collins, formerly physician and surgeon, Bath. As there is no medical candidate for the Royal Masonic Institution for Girls votes for that institution can be exchanged and are equally valuable. Votes for either institution will be gratefully received and acknowledged by me.

I am, Sir, yours faithfully,

WILLIAM WILSON,

Secretary, St. Luke's Medical Lodge of Instruction,
184, Goldhawk-road, W.

RHUS TOXICODENDRON AND ARNICA.

To the Editor of THE LANCET.

SIR,—Your annotation on the subject of rhus toxicodendron in THE LANCET of Sept. 19th, p. 887, interested me, because during the last 12 months I have had under my care two cases of dermatitis which were caused by the climbing variety of this plant. Application of a lotion, containing acetate of lead and tincture of opium, gave so little relief that I resorted to a solution of picric acid (picric acid, grs. 4; sp. vini meth., min. 60; aq. destill., ad 1 oz.).

Some years ago I was called to see a woman who was suffering from a most severe form of dermatitis. She had sprained her wrist and her hostess, a keen amateur homoeopath, had applied bandages soaked in arnica lotion, with the result that the patient's hands, wrists, and forearms were inflamed and covered with blisters. Not knowing an antidote for the local effects of arnica we decided to treat the case as a severe scald and used picric solution with very good result. The skin lesions produced by rhus toxicodendron and arnica resemble one another very closely, and the remedy which had acted well for arnica proved equally efficacious for rhus toxicodendron. The solution was applied in the form of compresses, where these could be easily kept in position by a light bandage, and to the parts where this was inconvenient the lotion was applied frequently with a very soft camel-hair brush. It quickly relieved the pain and hastened the healing of the blistered surfaces. The only drawback is its vivid yellow stain which takes a few days to fade away. Some chemists are unwilling to keep picric acid in stock because of its dangerous explosive properties; the solution, however, is perfectly harmless.

As for the therapeutic uses of rhus toxicodendron I have found it of some value in the treatment of that troublesome symptom, nocturnal incontinence of urine. I have given the tincture in five-minim doses, combined with nux vomica and buchu, to a number of young school boys who were suffering from this weakness. It has certainly failed in a few very