RHAMNUS PURSHIANA.—U. S.—*Cascara Sagrada*, or “sacred bark,” is directed to be gathered a year before being used. It was introduced into medical practice in 1877, but as a domestic remedy in habitual constipation it was in use some time before that date in the region to which it is indigenous—the Pacific slope. It is now official in a number of pharmacopœias. It is not given in substance.

FLUIDEXTRACTUM RHAMNI PURSHIANÆ.—U. S.—This is prepared with 40 per cent. alcohol.

Average dose: 1 c.c. (15 minims).

FLUIDEXTRACTUM RHAMNI PURSHIANÆ AROMATICUM.—U. S. The crude drug contains a bitter acid principle which is neutralized in this preparation with magnesia, orange and glycyrrhiza being added to flavor and sweeten it. There is no special skill required in making this preparation, and any reputable pharmacist can make it equally as well as the manufacturers who put it on the market in the form of proprietary preparations.

Average dose: 1 c.c. (15 minims).

EXTRACTUM RHAMNI PURSHIANÆ.—U. S.

Average dose: 0.25 gm. (4 grains).

Cascara sagrada is probably the most useful laxative in the materia medica for chronic constipation. Unlike most of these remedies, which demand increasing doses, it improves the digestion, and the dose may be gradually diminished. Owing to the very disagreeable taste of the fluid extract, the aromatic fluid extract, or the extract, in pills or capsules, is to be preferred.

(To be continued.)

Clinical Reports

REPORT OF TWO CASES OF MALIGNANT ENDOCARDITIS.

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SAN FRANCISCO.

CASE 1.—F. D., boy, aged 16.

History.—Both of his parents are alive and well. The boy had always been well up to a month before entering St. Thomas Hospital. At that time he contracted an attack of gonorrhea and about a week later suffered from what was considered la grippe, with throat symptoms predominating. The illness which brought him to the hospital was diagnosed typhoid fever and was of about a week's duration. He had pains in his back and head, fever and delirium.

Examination.—Physical examination showed a well-developed and well-nourished boy. He was partly delirious and very apathetic. Pulse was 110, temperature 103.6. The eyes reacted to light and to accommodation. The tongue was flabby and coated. The lungs were negative.

Examination of the heart showed diffuse, forcible pulsation visible over the whole heart area, and more pronounced at the apex. This pulsation was also readily palpable. Percussion showed an enlarged heart area in all directions, especially downward and to the left. Auscultation revealed an extremely loud, harsh systolic murmur heard over all the heart area, but more distinctly at the apex. This murmur was transmitted to the left axilla and to the angle of the scapula. The pulmonic second sound was accentuated.

The spleen was greatly enlarged, tender and readily palpable. The liver extended downward to the level of the umbilicus and was tender on palpation. The abdomen was distended, painful and tympanitic. No roseola was seen. The left elbow was slightly swollen, red and tender. The urethra showed a purulent discharge containing gonococci. The reflexes were normal.

Course of the Disease.—During the two weeks the patient lived after his entrance to the hospital he was more or less delirious and sweated profusely. His pulse ranged from 90 to 140, and the temperature from 99 (almost normal) to 105.

Blood examinations showed 14,500 leucocytes, 4,000,000 reds, and 70 per cent. hemoglobin. Differential counts showed the number of polymorphonuclear neutrophils to be relatively largely increased. No plasmodia were seen. The Widal test was negative. The urine showed a large amount of albumin,

with hyaline and granular casts. The diazo reaction was negative.

Diagnosis.—The laboratory findings all seemed against the diagnosis of typhoid fever, so a diagnosis of malignant endocarditis was considered. It was difficult to say whether the endocarditis was due to a gonorrheal infection or whether the attack of la grippe was really rheumatic, with the chief symptoms showing in the throat. The fact that only one joint, the left elbow, was involved rather pointed to a gonorrheal origin.

Treatment.—The patient was given supportive treatment, and the usual remedies in endocarditis were administered, but without avail. The boy died about two weeks after his entrance to the hospital.

Autopsy.—A partial autopsy was allowed by his parents and this was performed by Dr. Philip King Brown.

The lungs were normal. The heart was greatly enlarged and softened and there were many fresh vegetations on the mitral valve. A small abscess was present near the base of the aorta. The spleen and kidneys both contained many septic infarcts. A small abscess was present in the prostate gland.

Cultures from the mitral valve, the base of the aorta, and the prostate showed a typical growth of the gonococcus of Neisser.

CASE 2.—Mrs. S. T., Italian, aged 35, was the mother of six children, and had had one miscarriage between the third and fourth child.

History.—The patient was always a large, healthy woman until two years ago, when she had an attack of acute articular rheumatism. From that time until five months ago, when her present trouble began, she had fainting attacks at irregular intervals. The present trouble began with an attack of right-sided pneumonia, since which she had lost weight and strength and had had daily attacks of sweating. Her appetite had been very poor and capricious. During these months she was treated for malaria.

Examination.—Physical examination at St. Thomas Hospital showed a thin, debilitated woman, very apathetic, complaining of pains in her head and limbs. Her appetite was poor and the bowels were constipated. Temperature was 101 and pulse 106. Inspection of the eyes showed pupils equal and sclera quite yellow. The tongue was clean. The lungs were normal.

Examination of the heart showed visible and palpable impulse over the precordial area, most pronounced at the mid-apex. The left border of the heart was just outside of the left clavicular line. A harsh mitral murmur at the apex was transmitted to the left axilla and to the angle of the scapula. The liver was not enlarged or tender. The spleen was not palpable or tender. The abdomen was not distended or tender, although the patient complained of pain about the umbilicus and in the epigastrium. There was no roseola. Nothing abnormal was found on vaginal or rectal examination. The reflexes were normal, and examination of sputum for tubercle bacilli was negative.

Blood examination showed white cells, 15,500, with a large relative increase of polymorphonuclear neutrophils; red cells, 4,100,000, and hemoglobin 70 per cent. No nucleated red cells or plasmodia were seen.

The urine contained granular casts, but no albumin. The diazo reaction was negative, as was the Widal test. The bowel movements were small and dark colored. No intestinal parasites or their ova were present.

Course of the Disease.—The patient kept getting gradually worse and had daily sweats and pain in head and limbs. Two days before death she developed a left-sided hemiplegia.

Diagnosis.—There being no other physical signs present but the enlarged heart and mitral murmur, and the blood findings and previous history of rheumatism and pneumonia pointing in that direction, a diagnosis of malignant endocarditis was made.

Typhoid fever was eliminated by the length of time she had been ill, the number of leucocytes, 15,500, and the absence of the diazo and Widal reactions. No tubercle bacilli being present in the sputum and no physical signs being present in the lungs, tuberculosis seemed unlikely. There was no wound or focus of infection discoverable, other than the heart, to ac-

count for a pyemia. Malaria could be excluded by the leucocyte count, the character of the cells and the absence of plasmodia. Uncinariasis was considered, but the absence of eosinophiles in the blood and of the ova of the parasite in the stools made this improbable. The development of the hemiplegia just before death strengthened the diagnosis of endocarditis, as the symptom was probably due to an embolus.

Autopsy.—A partial autopsy was obtained. This showed the lungs to be free from disease, except for some old adhesions of the right pleura to the chest wall. The heart was enlarged and both new and old vegetations were present at the mitral valve, one of the new ones being as large as a white bean. The abdominal organs were normal and no latent gallstones were present in the gall bladder.

Cultures from the mitral valve were taken. These were examined by Dr. Harold Brunn in the laboratory of the medical department of the University of California and a pure growth of pneumococcus was found.

A REMEDY FOR CHOLERA.

REV. CLARENCE D. USSHER, M.D.

VAN, TURKEY, ASIA.

Recently I picked up a piece of paper, apparently cut from some medical journal for the purpose of reinforcing a binding, and my eye caught the statement, by some one who apparently wrote as an authority, that "until now no remedy for cholera has been discovered," "all bad cases die [*sic*], in spite of remedies." The writer also expressed the opinion that the patients who recover would recover without medicine. About the same time I learned that cholera was spreading in Europe and that there was panic in places.

These things lead me to feel that I have been remiss in my duty as a physician in not putting definitely before the profession the results of treatment of cholera in Van during an epidemic of six weeks' or more duration in the early part of this year.

As the only foreign physician within a week's journey in any direction, my duties are heavy and prevent me from making a scientific report or even keeping satisfactory records of the numerous cases seen. I wish simply to report a fact and to let others work out details for themselves.

I claim no credit as discoverer of the remedy, nor for its application. Koch of Berlin discovered that "quinin in solution of from 1/1000 to 1/2500 would kill the cholera germ in from ten to thirty minutes." This was applied by Graham and reported by E. B. Fullerton¹ of Columbus, Ohio, from whose report I obtained my suggestion. I wish to corroborate the statements made there and to say that cholera has lost its horrors here through the use of quinin sulphate (or bisulphate, preferably the sulphate) in ten-grain doses every hour till bile reappears in stools; from forty to eighty grains have been given. The quinin is not absorbed, but acts in the intestines. Aromatic sulphuric acid lemonade proved a satisfactory prophylactic. Sulphate of copper, 1 to 100,000, for drinking and washing purposes stopped the disease and stamped out the epidemic in the military barracks where hundreds had died.

With quinin, more than 90 per cent. of the patients recovered, including those brought to our hospital moribund.

With the old lines of treatment, every patient during the first week succumbed, testifying to the virulence of the epidemic. Saturday night at midnight I learned of the new remedy, and after that lost but two patients seen before they were moribund.

Our hospital treatment consisted of the following: Quinin sulphate, gr. 10, every hour till rice-water stools ceased and bile reappeared; sweet spirits of niter, dry cupping heat and friction for suppression of urine; saline injections when the wrist pulse had disappeared (but some patients in this condition recovered under quinin treatment without injections). Occasionally a diarrhea mixture was used when intestinal activity was excessive after the reappearance of bile in the stools. Where irritability with foul odor persisted, five grains of a mixture of equal parts of the sulphophenolates of zinc,

calcium and sodium were given at intervals of from two to four hours.

I am so fully persuaded that quinin is nearly a specific for cholera that I feel it my duty to ask you to give this as wide publicity as possible.

A Columbus physician has criticised missionary physicians for not giving the world more benefit from their necessarily large experience. For my part I must confess that my seclusion here for eight years makes me diffident about putting my humble thoughts before my more scientific brethren who have kept abreast of the times.

EPIGASTRIC MURMUR CAUSED BY A DISPLACED DISTENDED GALL BLADDER.

C. M. COOPER, M.B., M.R.C.S.

SAN FRANCISCO.

Epigastric murmurs are well known to be of both intravascular and extravascular origin. Thus any tumors which lie over the artery, e. g., a pyloric or pancreatic carcinoma may press on this vessel and give rise to systolic murmur or to a marked visible localized pulsation. Hence it has become a well-recognized clinical custom to examine patients who present localized pulsations and murmurs of doubtful origin in the knee-chest position. I wish, however, to report a case in which localized pulsation which was actually expansile, together with a systolic bruit, were present in the epigastric region, these signs being due to a distended, displaced gall bladder. The key to the diagnosis lay in the disappearance and reappearance of these signs coincident with the partial emptying and refilling of the cystic swelling. Operation demonstrated the mesial position of the gall bladder. After operation the murmur disappeared, and an autopsy some months later showed an absence of any arterial abnormality. Such a case suggests that we should not only examine these patients in the knee-chest position, but also in the right and left lateral postures so that the falling back of displaced organs into their original lateral position may be favored and thus elimination be made more comprehensive. Systolic murmurs, of course, have been long known to occur in association with attacks of acute cholecystitis, as do friction murmurs, and probably too little attention is paid to these diagnostic auscultatory phenomena, but it is not in such a category that the above mentioned case belongs. I have notes of a somewhat similar case, in which, however, the diagnosis was not confirmed by operation or autopsy, and hence, though very suggestive, is unreportable. The co-existence of gall bladder disease with a murmur due to another cause not infrequently occurs. The adoption of the right and left lateral postures will, I believe, aid in the diagnosis.

ADAMS-STOKES' DISEASE.

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SAN FRANCISCO.

A case of Adams-Stokes' disease which I had the opportunity to observe presented symptoms of heart block. There were from three to four auricular contractions to one ventricular beat. During the attacks the ventricle stopped entirely, while the auricular rhythm kept on undisturbed. The patient died after twenty-four hours.

In view of the experimental work on heart block done by Erlanger and Hering I felt justified in diagnosing a lesion of the auriculo-ventricular bundle of His.

The postmortem was limited to the heart. Macroscopically no lesion could be detected, but the microscopic examination by Dr. Ophüls showed scar formation in and around the bundle of His just below the membranous septum.

1. *Safous Annual*, 1896, D. 12.