to work better, remember messages more accurately, and the patient said he could "learn and recite his Sunday-school lesson better." I had ample opportunity to watch this case closely, and to differentiate the effects of the various remedies used at different times, and my conclusion is that the single hypophosphites were decidedly efficacious in the latter stages of this case.

The theory which led me to their use may be stated as follows:

In cases of gummata of long standing, the contiguous parts of the brain are subjected to constant pressure, interfering seriously, not only with their functional activity, but with the nutrition of the cells and fibers which enter into their structure. After the gummata have been partially or fully absorbed under the influence of the heroic doses of iodid of potassium—so that the brain tissue has the opportunity to expand again to something like its normal size and shape—these compressed, starved and dwarfed fibers and cells need some restorative remedy, some special nerve *nutrient*, to assist in this development. Nothing so naturally suggests itself to the medical mind for this purpose, as phosphorus in some available form.

As the single hypophosphites are my favorite preparation of phosphorus for almost all its uses, I prescribed them in this case, with the results recorded above. I have reason to believe the effects can be duplicated in other similar cases. In an old case, as this was, even when it first came to me, the physician must not expect too much of any remedy. Parts of the brain structure have been absorbed under the long-continued pressure. Other parts, even though remaining, have been so damaged, that their integrity can not, probably, be fully restored, or their functions rendered strictly normal.

In conclusion, let me warn my reader who feels sufficient interest to test the matter, not to begin the restorative treatment too early in the development of the case.

THE PHYSICIAN AND THE PHARMACIST.

A Volunteer Paper read in the Section on Materia Medica and Pharmacy at the Forty-fourth Annual Meeting of the American Medical Association.

BY L. CH. BOISLINIERE, M.D.
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A few words of protest and advice are herein offered from an old practitioner. I believe in the profession of pharmacy and I highly respect the pharmacists. They are the hand-maids of the physicians and our best friends, often our useful advisers. The two professions should work in harmony, one not encroaching upon the specialty of the other. Therefore the pharmacist should not tolerate any counter-prescribing, and the physician should not dispense his own medicines. I therefore most strongly protest against the custom, lately too frequently resorted to by physicians, of distributing among their patients any of the potent triturates, or dosimetric granules, so elegantly put upon the market by otherwise reliable wholesale dealers. This practice is enticing, but it is often dangerous.

This protest applies chiefly to the city physicians; an exception should be made in favor of the country practitioners. For them it may be sometimes absolutely necessary and is often very convenient; they are so placed that they can not do otherwise; but it is a practice fraught with danger.

This practice, in cities especially, may be followed by suits for malpractice in case of any accident. The prescriptions on file with the pharmacist are a strong protection to the physician, as they can be referred to, and, if necessary, brought into court in case of a suit for damages. While serving as Coroner of St. Louis County, several cases of this kind came under my official notice for investigation. One was the case of a woman, for whom a most reputable physician had prescribed a mild cough mixture. The husband, at the inquest, stated that his wife walked in the garden, after taking a teaspoonful of the medicine, and dropped dead, as if shot. Happily, the bottle of medicine was in the house, properly numbered, and came from a very good pharmacist. The prescription from the file was brought to the house of the deceased and shown to the jury to be a harmless mixture. This, however, did not entirely satisfy the husband. In order to convince him, I opened the deceased's chest and showed him the heart; the pericardium was enormously distended; puncturing it, I received in a cup nearly a pint of serum. The woman had died of acute pericarditis. This amount of serum, pressing on the heart, had caused its sudden stoppage and the patient's death. The husband was satisfied and the physician discharged.

Upon another occasion, an old man had had a weak solution of morphia prescribed for nervousness. The next day I called at the house and found the front parlor full of people and crape at the door. On my inquiring about the patient his sister rushed in, in a fury, and exclaimed to me: "You dare inquire about my brother! You killed him! He walked to the mantelpiece, took a teaspoonful of your infernal mixture and dropped dead!" He died of paralysis of the heart, as was afterwards ascertained. The pharmacist, an excellent one, was requested to come immediately with the prescription, which he had on file, and which called for one grain of sulphate of morphia, of which the patient had taken one teaspoonful, equivalent to one-eighth of a grain, which certainly is not a poisonous dose. The family was finally satisfied that the fatal result was not connected with the medicine.

From these cases is seen the great advantage of filing, dating and numbering prescriptions.

In another instance, there was prescribed for a young woman a one-eighth grain dose of morphia; but, through the accidental misplacement of the bottles, she took one teaspoonful of strong sulphuric acid, and would have died had it not been for copious draughts of water, mixed with plaster scraped from the walls of the room. For several months, she could swallow nothing but milk, as she had an extensive inflammatory stricture of the esophagus.

Here the pharmacist was called in to show that the prescribed mixture was a weak solution of morphia and not sulphuric acid, which it was subsequently learned had been left carelessly in the room to acidulate a battery. I could relate more cases, but these are sufficient to illustrate my position, that often the pharmacist is the best protector of the physician.

Another point to be considered is this: Quite a reprehensible custom is that of pharmacists, on demand of patients or their friends, repeating prescriptions without the order of the physician. This is done generally because it would be impolite to refuse; moreover, they have nothing to gain by it. This indefinite refilling of prescriptions should not be

done, because it makes the patient his own prescriber, often to his own detriment, as no two patients or diseases are alike. It is a dangerous practice, and should be abolished by a mutual agreement with the pharmacists. This practice is often resorted to by designing persons for mercenary purposes. I will briefly recite a case to illustrate:

I once prescribed a mild but efficient cough mixture. What was my amazement when I ascertained that the formula had been printed and sold to many acquaintances for twenty-five cents a copy. Let, then, physicians and pharmacists live in perfect harmony, following their useful and noble professions, each respecting and protecting the other.

RETRO-PHARYNGEAL ABSCESS—WITH REPORT OF CASE.

BY REVERE H. HERROLD, M.D.

CHICAGO, ILL.

Miss T; age, 22; native of Sweden; occupation, clerk; left the land of her nativity in August, 1893, in good health as far as can be discovered. August 29 I saw her for the first time, and received a history of previous good health, except that a week before, she was seized with choking and pharyngeal spasms. These symptoms passed away and none appeared again until the day of my visit, when I found the spasms and choking present, with cyanosis, greatly increased during the pharyngeal spasms. Examination of the throat with the finger revealed no pathologic condition, leaving thus a doubt as to what caused the spasms and choking. Anti-spasmodics were administered, which only partially relieved. The patient having stated that no passage from the bowels had occurred for several days, a cathartic was prescribed and the patient left for a time. In less than an hour I was again called, and found that the cathartic, which was a powder, was being expelled from the mouth by what at first appeared to be mucus but later was found to be pus. The attempt to swallow the powder caused the rupture of abscess, which was located very low. The patient became unconscious and remained so to the time of her death. Continuous symptoms were manifest here for about thirty-five hours. The symptoms a week previous were of such short duration that no physician was called.

There is a feature of this case which deserves mentioning. The deceased left her native land to meet and marry her lover. Having no means of her own, the lover paid for her physician and saw that she received a respectable burying.

In making a brief review of this subject it may be said that a retro-pharyngeal abscess is the result of a suppurating cellulitis in the areolar tissue between the pharynx and the vertebræ, and frequently not in the median line. It is primary or secondary according to its previous pathologic state. The cause, if primary, is atmospheric or due to some irritating substance lodged in the pharynx. The secondary form may occur after measles and scarlet fever. The inflammation of the pharynx common in those diseases extends to the subjacent connective tissue and becomes suppurative. Caries of the cervical vertebræ is, however, the most frequent cause of the secondary form. When it originates in this manner it is similar to a lumbar abscess except that its proximity to the air passages renders the symptoms more urgent and dangerous. Erysipelas, syphilis, inflammation of the inferior maxilla, cerebritis and scrofula have been followed by a retro-pharyngeal abscess. Small lymphatic glands which lie in the connective tissue external to the pharynx, are undoubtedly the original seat of suppuration in a majority of cases. Often the abscess may be seen or fluctuation felt by

the finger, but when, as in the case reported, the abscess is low, it can not be positively diagnosed. It may be said, however, that when it is due to caries it is preceded by deep-seated pain, greatly increased by movements of the head. The symptoms usually described are those of restlessness, mouth dry and hot, deglutition more or less difficult, the tongue furred. After suppuration there may be alternations of rigors and fever. The tissues chiefly involved are the submucous, and the degree of redness of the mucous surface is less than where the mucous membrane is chiefly involved. Chilliness and convulsions occasionally occur, but embarrassment of respiration is the chief cause of danger, frequently beginning early, and becoming more and more prominent as the abscess increases. Dysphagia is present, and is sometimes so great that solid foods are refused, and drinks taken with difficulty.

The disease may be mistaken for protracted laryngitis owing to the resemblance in the respiratory symptoms; the voice is feeble or indistinct from the pressure of the tumor, and the respiration sometimes whistling and impeded. Dyspnea increases as the abscess enlarges, and imperfect oxygenation of the blood follows unless the abscess is opened or it ruptures spontaneously. Paroxysms of dyspnea may occur so as to threaten suffocation. The pulse is frequent and rapid, the head is thrown back, the tongue protruded, and the patient is forced to remain in a semi-erect posture. The limbs become cool, livid. Finally death results from dyspnea. Even if the abscess rupture, life may not be saved in all cases, as the case herewith submitted illustrates. If the trachea and bronchial tubes are deluged by the purulent discharge, suffocation follows. Another example of this is found in the records of the Bellevue Hospital. In May, 1871, a boy, age two and a half years, having symptoms of an abscess for three months, was brought before the Hospital class. The patient's head was carried sidewise, and rotation of the head caused pain. A laryngeal râle accompanied respiration. In this case the upper part of the tumor could be detected by the finger, but its location was so low that it could not be opened with a bistoury. Dyspnea came on and death being imminent, the class physician, Dr. Swezey, broke the abscess with his finger and pus was ejected, but death occurred almost immediately. Most of the cases reported are of infants and children. The case submitted by me occurred in a lady 22 years old. It can not be precisely ascertained when an abscess begins to form, nor can its duration be foretold. The duration will depend upon the rapidity of growth, and the direction in which it points; a lateral or downward extension not being so immediately dangerous to life as an anterior.

We should not lose sight of the fact that the thickness and the density of the wall of the abscess varies greatly. Thus Dr. W. C. Worthington reported a case in 1842 in the *Provincial Medical and Surgical Journal*, in which the case occurred from exposure to cold. The patient was a child and was treated for croup. It died from suffocation. In this case the anterior wall of the abscess was very thin. On the other hand, Dr. E. O. Hocken relates a case in the same journal and the same year, where the abscess seems to have been present from birth, the infant dying at the age of 9 weeks. It had always thrown back its head as if suffocating when taking the breast