not yet become trained for long, arduous and painstaking investigation, but this should not exclude the few who are.

There are many very carefully reported clinical phenomena recorded by American physicians in American journals which, if allowed to go unnoticed, would be not only an injustice to the individual worker but a positive loss to medical science.

We hope the time is near at hand when American reviewers of medicine will fully acquit themselves of the stigma of slighting any medical investigators of whatever nationality, and we also hope that foreign reviewers, too, will speedily mend their ways.

Very truly,

L. PIERCE CLARK.

Naphthalin in Typhoid Fever.

BUFFALO, N. Y., April 22, 1899.

To the Editor:—Dr. Woldert's article in the *JOURNAL* of April 15, on the use of naphthalin in typhoid, is so much in line with my own hobby, that I may be pardoned for a brief discussion of the subject. In August, 1895, I published (*Boston Med. and Surg. Journal*) a report of the use of charcoal and such direct antiseptics as iodoform and salol in the treatment of typhoid and, since then, I have used salacetol as the active antiseptic, in preference to the benzol and double benzol derivatives. It seems to me that the main object to be attained in the treatment of typhoid is the reduction of associated infectious processes. We all acknowledge now that the elevation of temperature is not the prime consideration, and, considering that leucocytosis is not normal to the course of the disease, even in favorable cases, I can not see why its artificial production by the Brand baths should be attempted. In such diseases as diphtheria, pneumonia, septicemia, etc., it is quite well established that a mixed infection is vastly more dangerous than one representing practically the pure culture of one bacterium. So, in typhoid, if we can have merely typhoid, without intestinal putrefaction and septic ulceration with corresponding involvement of the mesenteric lymph nodes, perhaps of the gall-bladder, pleura, lungs, etc., the patient remains only comfortably sick, delirium is lacking or at a minimum, the temperature is never dangerously high after treatment has had a few days to become operative, septic complications are lacking and convalescence begins in about three weeks. As Dr. Woldert has independently noted, the absence of indican is a practical evidence of the lack of intestinal putrefaction and of the favorable course of the fever. In my cases, the Ehrlich test has usually resulted negatively, indicating that the corresponding more or less specific poison has been absent.

Diet is also an important factor. It always used to puzzle me to understand why, in a disease of excessive oxidation, the natural force and fuel foods, fats and carbohydrates, should be withheld, why, in a disease of perverted nitrogenous change, animal foods should be used to add to the possible leucomains and other toxic derivatives from meats; why milk which curdles in the stomach should be a soft, unirritating mass in the intestine, while bread, etc., which melts into a pulp in the stomach, should bring on relapses by local effect on the iliac ulcers located nearly twenty feet from the pylorus; why, in the absence of digestive power on the part of the stomach, peptic digestion should be mainly relied on; why constipation should be a desideratum in a disease in which most of the elimination of bacteria and their products must take place by the bowel; why, if the bowels must be moved, it is dangerous to use salines and mercury, which act mainly on the hepatic secretion and that of the unaffected upper small intestine. Little by little, I have made practical application of these theoretic considerations and have found no exception to the general rule that it is safe to rely on physiologic laws.

Very truly,

A. L. BENEDICT, M.D.

174 Franklin St.

Dissemination of Tubercle Bacilli.

SAVANNAH, GA., April 20, 1899.

To the Editor:—Referring to the editorial in the *JOURNAL* of April 15 (p. 827), I think Flügge greatly exaggerates the danger of infection by means of the fine drops expelled from the mouths of phthisic persons in coughing. He has not by any means proved that tuberculosis is commonly transmitted by such drops. I believe the only danger, save in exceptional cases, of the open mouth coughing, is that such drops soon become dried and act as so much dried sputum. The danger of inhaling such drops under ordinary circumstances is slight.

Cornet's recent works proved conclusively that tuberculosis may be disseminated by dried sputum dust.

Very respectfully,

J. J. CURRY,

Acting Assistant-Surgeon U. S. A., Pathologist to the General Hospital, formerly assistant in pathology Harvard University.

Recurring Gonorrhea.

FORT WAYNE, IND., April 24, 1899.

To the Editor:—In the *JOURNAL* of April 22, Dr. Harry Greenberg, Milwaukee, reports a case under the above title, but this is a misnomer. It ought to be called "a non cured clap." An injection of a 1 to 2 per cent. solution of nitrate of silver would, in twenty-four hours, have cleansed the field, and the discharge would have revealed the gonococcus. This should always be done, before a patient can be said to be cured, and I even make culture experiments with pleuritic serum; this makes the diagnosis doubly sure. The physician ought always to be sure of his diagnosis; if he does not know how to handle a microscope or make culture experiments, let somebody do it who does.

CARL PROEGLER, M.D.

Current Medical Literature.

AMERICAN.

Titles marked with an asterisk (*) are noted below.

American Gynecological and Obstetrical Journal, April.

- 1.—*Reminiscences of Founders of the Woman's Hospital Association. Thomas Addis Emmett.
- 2.—*Plea for More Correct Application of the Emmett Methods in Plastic Surgery. W. D. Haggard, Jr.
- 3.—*Preliminary Report on Use of Doyen-Thumin Crusher with a New Instrument for Extending its Work on the Broad Ligaments. Henry Parker Newman.
- 4.—*Clinical Contribution to Treatment of Malignant Tumors of Ovary. X. O. Werder.
- 5.—*Caesarean Operation, with Report of Two Cases. A. McDiarmid.
- 6.—*Operations During Pregnancy. C. P. Noble.

American Journal of Obstetrics, April.

- 7.—*Diagnostic Value of Pain in Gynecology. Richard Lomer. Introduction by A. Sänger.
- 8.—*Clinical History of Uterine Polyps. B. C. Hirst.
- 9.—*Convenient Technic for Delivery of After-coming Head where Gross Disproportion Exists; with Comparative Considerations. Frank A. Stahl.
- 10.—*Phthisis in Pregnancy and Labor. W. Reynolds Wilson.
- 11.—*Treatment of Asphyxia in Children, by use of a Soft Rubber Catheter. S. Ormond Goldan.
- 12.—*Influenza Complicating Uterine and Pelvic Disease and Pregnancy. F. C. Ameiss.

International Medical Magazine, April.

- 13.—*Relation of Gout to Rheumatoid Arthritis. Wm. Ewart.
- 14.—*Dilatation of the Stomach, with Especial Reference to Etiology and Treatment. John A. Lichty.

Therapeutic Gazette, April.

- 15.—An Ophthalmic Clinic at the Jefferson Medical College Hospital. G. E. de Schweinitz.
- 16.—*Lumbar Puncture Followed by Relief of Symptoms—Four Cases. J. Madison Taylor.
- 17.—Morphin in Uremia. J. W. Meek.
- 18.—*Organotherapy in Gynecology. W. A. Newman Dorland.
- 19.—Tuberculous Peritonitis. Anna M. Fullerton.

Pediatrics, April 15.

- 20.—*Eight Cases of Laparotomy for Intussusception; Six Recoveries. Charles P. B. Clubbe.
- 21.—Second Contribution to Surgical Treatment of Intussusception, with Cases. Henry Howitt.
- 22.—Cases of Congenital Displacement of the Scapula. J. E. Virden.

Ophthalmic Record, April.

- 23.—*Necessity for Knowing Range of Accommodation. J. G. Huizinga.
- 24.—Histology and Etiology of Posterior Lenticonus. R. Denig.
- 25.—Diabetic Cataract with Report of Five Operations. Robert L. Randolph.