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.

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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.

E. SCHMOLL, M.D.

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.