from every secretion in the body. We recovered iodine from the sputum, from the urine, and from the feces. Of course, much of the iodine undoubtedly passed unchanged through the intestinal tract. But I have attempted to recover iodine in cases of its administration in as much as 60 grain doses, three times a day, from the spinal fluid, and I have found no trace of the iodine after the administration of 180 grains per day. Therefore, I have no reason to believe that iodine in this form accomplishes any results in the deeper forms of parenchymatous syphilis of the nervous system.

Dr. E. H. Martin (closing).—I wrote this paper at the request of the secretary of this Section, who suggested the title, knowing that ordinarily it is not a public health subject. But I thought that I could see reason to insist that everybody who has a venereal sore should be given a dose of salvarsan. I believe that it is the wisest thing to do; to give at least one dose of salvarsan to every case with a local sore, whether it be a chancre or a chancroid, or where you are in doubt. Also to cases with persistent extra-genital local infections of any doubtful sort.

In reply to the question asked by one of the speakers, I do not give mercury in the treatment of syphilis unless the home doctor of a patient requests it. Otherwise I have not given mercury in the treatment of syphilis for five years, and I find that the patients get along much better without it. The proof of the pudding is in the eating, and not in chewing the bag string. The patients who have come back do not return with recurrences of syphilis, but with new cases of syphilis,—reinfections. I wish to assure Dr. Minor that I am not a genito-urinary specialist. I am a general practitioner, and the syphilitic patients that come to me amount to but 23% of the total. But that gives me enough material upon which to base opinions.

As to the use of iodids, I have used them more recently than mercury, but have discarded them for the sake of the patient's stomach and because nature takes care that absorption takes place if we kill the causative organism. I have watched gummata disappear just as rapidly without anything at all except weekly doses of salvarsan as under heavy doses of iodid of potassium.

Now to explain that stomach chancre. It was Dr. Wootton's case. I am sorry he is not present. This patient came to Dr. Wootton with every evidence of gastric ulcer. After having been treated for two or three weeks in a routine manner, he had an early secondary rash. He had no other evidences of chancre than the gastric ulcer. Being before the days of salvarsan, Dr. Wootton put the patient upon inunctions of mercury and the stomach ulcer was soon well.

Dr. Minor.—Is that enough to diagnose chancre of the stomach?

Dr. Martin.—Yes. That early secondary rash occurs but once, and it occurs within from three weeks to three months after a chancre appears, and the only other lesion this man had was in his stomach condition.

The preparation for intravenous work is very simple, and as so many drugs are now being given intravenously in a few years the country doctor will be able to give salvarsan ten miles from his

office and give it in the vein with perfect technic.

Dr. Krauss sounded a note which is of the utmost importance to this Section from the standpoint of public health whether you agree with me in the treatment of syphilis or not: Every case of syphilis should be thoroughly sterilized as early as possible by repeated doses of salvarsan.

In answer to Dr. Bass, I have seen no deaths from treatment with salvarsan. I have seen one death from congestion of the kidneys two weeks after a dose of arsenobenzol, whether due to the drug or to idiosyncrasy I cannot say.

Dr. Graves is correct in stating that we cannot relieve the scar. If a man has a syphilitic ulcer on the face we can cure the ulcer, but we cannot take the scar away. We cannot relieve all cases of cerebro-spinal syphilis, because there is often too much damage done, and in some cases the treponemata are outside the blood stream.

AUTHORS' ABSTRACTS

Medicine

Primary Cancer of the Liver. Report of Case With Autopsy Findings. H. T. Brooks, Memphis, Tenn., *Memphis Medical Monthly*, December 1, 1916, p. 272.

A careful review of the literature shows primary liver carcinoma quite rare. Hale White found only eleven cases in 11,500 necropsies.

In the gross there are three types: First, the nodular type, in which various sized nodules occur throughout the liver; secondly, the massive type, in which the entire or a greater part of the lobe is replaced by the tumor mass with often secondary nodules surrounding this; and thirdly, the diffuse type, in which the liver shows numerous very small nodules, each being surrounded by a connecting tissue capsule.

Microscopically two forms exist: first, carcinoma simplex, in which the cells occur in solid masses; and secondly, adeno-carcinoma, in which the cells occur in the form of atypical glands. In both types, however, the cells appear sharply defined and well stained as newly regenerated cells do.

The origin of a primary liver carcinoma is from the liver cells proper, or from the bile duct epithelium. In either case the cells composing the tumor mass resemble, more or less, the form and arrangement of the cells from which they arise.

The parenchyma cells of the liver have considerable regenerative capacity, as experimentally one may remove from one-third to one-half of the liver with the restoration to normal. This great capacity of regeneration is probably responsible for the occasional occurrence of primary carcinoma in the liver, it being, however, necessary for some poison to bring about necrosis, which necrosis starts the process of regeneration.

The majority of primary liver carcinomas, from 75 to 80 per cent., are associated with Laennec's cirrhosis, and give a past history of ingestion of alcohol-containing fluids. It is, therefore, believed that the alcohol is responsible for

the necrosis of the liver cells, and also for the hyperplasia of connective tissue; as result of the necrosis, regeneration of the liver cells occur to restore the organ to normal, and these rapidly-growing liver cells may, and occasionally do, pass beyond this requirement, and continuing to proliferate, become malignant.

The case reported by the author occurred in a colored man, aged 65, with a previous history of prolonged use of alcohol. Clinical examination showed an emaciated anemic man with ascites and enlarged spleen. Necropsy revealed a primary tumor mass in the left lobe with numerous small secondary nodules scattered throughout the right lobe. The surface of the liver showed the typical hob-nailed appearance characteristic of Laennec's cirrhosis of the stage of atrophy.

Microscopically, the nodules were composed of cells resembling bile duct epithelium. The other parts of the liver showed all the characteristics of atrophic cirrhosis, such as, increased fibrous connective tissue, round cell infiltration, etc.

Anatomical diagnosis: Primary adeno-carcinoma of liver associated with Laennec's cirrhosis.

Some Important Diagnostic Points the General Practitioner Should Know About the Nose. Gaylord C. Hall, Louisville, Ky. Kentucky Medical Journal, Vol. XV., No. 2, February 1, 1917, p. 58.

The author discusses obstruction, discharge, hemorrhage, pain, tenderness, and headache.

Under obstruction in infancy, he calls attention to "snuffles," due to syphilis; to stopped up noses in babies with over feeding, over dressing, and insufficient fresh air. It is possible to have adenoids at this time requiring removal. In childhood tonsils and adenoids are the most frequent cause; sometimes diphtheria. Be on the lookout for foreign bodies in one-sided obstruction. In adults obstruction may be due to many causes. To differentiate use the head mirror, nasal speculum, and shrink the parts.

Under discharge he discusses the diagnostic value of the source of the discharge in diseases of the different sinuses.

Under hemorrhage he considers nose bleed as a symptom, a disease, or a remedy. Most hemorrhages occur from the anterior lower septal region and hemorrhage is best controlled by cauterization without packing with energetic treatment of the general condition.

Under pain is discussed the location at the root of the nose, or deep under the skull. It occurs in the morning, due to pressure of pent-up secretions. Drainage relieves it. Internal remedies do not control pain well. Shrinking of the parts and inhalations of steam are efficacious.

Under tenderness he calls attention to pressure points over the frontal, the antrum, and between the eyes for the ethmoids. In determining the involvement of the sinuses, pressure should be made with the ball of the finger equally on each side. The difference is carefully noted.

Headaches have the same general intention as pain.

Concluding, he urges the general practitioner to

become familiar with the use of the nasal speculum and head mirror, and more familiar with the anatomy of the nose. By application of this knowledge, he can solve many problems in nasal pathology.

Some Important Diagnostic Points the General Practitioner Should Know About the Ear. Seldon Cohn, Fulton, Ky. Kentucky Medical Journal, Vol. XV, No. 2, February 1, 1917, p. 55.

One of the most important diagnostic points of acute ear affection is pain. The first symptom we have is earache, so common in some families as to be thought one of the necessary ills of childhood. A child subject to earache is in danger of deafness, and no care should be spared not only for its relief, but also in ascertaining and removing the cause. It rarely will be found even after a single attack of pain that the hearing of the afflicted ear is normal. The pain may vary from a dull ache to most intense anguish; often the pain is most severe at night. In children too young to tell the cause of distress, its seat will often be pointed out by unconscious movements of the hand to the affected ear. Frequently in young children after several days of suffering a discharge of pus reveals the diagnosis. So when a child cries from an unknown cause the ear should be investigated.

The pain is not always confined to the ears, but extends to adjacent parts. Frequently the pain extends to the teeth, until the patient scarcely knows whether toothache or earache predominates. The severity of the pain is to some extent a gauge of the violence and character of the inflammation, and the severer form, especially when constant, indicates the probability of suppuration with all its attending dangers.

As in many diseases, the presence of pain is fortunate, for it comes as a warning of impending danger to the hearing, demanding instant relief which shall furnish a safeguard against rapid impairment of a delicate organ. Subjective noises of some kind are rarely absent. Children often mistake these sensations for real objective noises, and inquiry as to their meaning is sometimes the first indication of the existence of disturbances in the ears.

Some Theories and a Few Facts About Headache. G. Werley, El Paso, Tex. Southwestern Medicine, Vol. I, No. 1, January, 1917, p. 29.

The three common types of headaches seen by the general practitioner are the migrainous, the indurative or rheumatic, and headaches of exhaustion. About two-fifths of all chronic headaches are of the migrainous type, and another two-fifths are rheumatic. Some points in the diagnosis of migraine are: A history of heredity; it is unilateral in about two-thirds of the cases; the majority of sufferers are women, and the attacks frequently occur at the menstrual time; it is as common among the poor as the rich; and the pupils are contracted during the attack. A headache that begins late in life is not true migraine; a continuous headache is not migraine. Rheumatic headache begins late in life, is very chronic and the pain is practically continuous. It starts as a rule in the occipital region, but later may spread