of course be watched carefully. From the evidence so far gathered the orthostatic albuminuria would not signify that he will be more subject to nephritis in late years since there seems to be some slight evidence of its tendency to decrease or disappear during the four years of the ordinary college curriculum.

Hence it would seem justifiable to disregard the transitory type of albuminuria except as an index of physical ability during a definite time of life. The orthostatic type, on the other hand, while indicative of no physical deficiency serious enough to bar the individual from athletics, seems worthy of close observation.

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A GENERAL PRACTITIONER'S PRACTICE

BY PAUL RICHMOND WITHINGTON, M.D., MILTON, MASS.

WHEN I was about to graduate from the medical school I tried to find out what sort of a hospital appointment would be of the most value to a man who wished to do a general practice outside of, but easily accessible to, a large city. All of my medical friends advised me to take a medical appointment, all my surgical ones said, "You will find surgery of more value." Of my friends who specialized, each held that his specialty would be of the most use, should I be able to take a supplementary appointment. Obviously the number of appointments that one man can take are limited, and it has occurred to me that perhaps the tabulation of cases actually seen in the first ten months of a practice such as mine might be of assistance to others who, in the future, will have to decide the same question for themselves.

Before giving the table and my conclusions from it, I should like to report in some detail two of the cases which were of special interest.

The first is that of a girl of 18, seen by me on April 19, 1920, during the temporary absence of a colleague. Her family history was negative. P. H.—She has had measles, mumps, pertussis, and influenza. She has also had fre-

quent, sore throats which had left her with a "strained heart muscle," and until this year her exercises had been limited. Now, however, she plays baseball and hockey. Last summer she had "renal colic." P. I.—On the afternoon on which I saw her, she had played baseball. At dinner, though not hungry, she had eaten soup, chicken, potato, and squash. Two hours later she vomited, and complained of a persistent, non-radiating pain in her right "hip." Her bowels were always irregular. Ctm. always irregular, one week early or late—the last, three weeks ago. P. E.—T., 99.4°. P., 88. W. d. and n., restless, pale girl. Heart and lungs entirely negative. Abdomen also negative, save for a slight rigidity and tenderness in R. L. Q.—no true spasm. No costo-vertebral tenderness. Knee jerks normal. Hip negative. B. P.—120/85. W.B.C. 10,800. Hgbl., 70%. Urine—Turbid, pink, alk.; sugar absent; alb., V.S.T. On centrifuging, blood macroscopically in large quantity. Microscopically epithelial and squamous cells. Much blood. Amorphous urates and cystin crystals.

The condition is not common; one authority says but 131 cases are on record. Cystinuria is frequently hereditary (though no history of heredity was obtained in this case), and often causes gravel in the urinary tract.

The second case was that of a cyanotic engineer who was sent by his "boss" to an insurance office where I was, "to see if his heart condition made it safe for him to operate his locomotive." A casual examination of heart and lungs was, to my surprise, entirely negative. I therefore had him go to my office for a fuller physical examination. To my further surprise his blood examination was not abnormal. His Wassermann was negative. I was at a loss, but went over his history again more carefully; it gave me the solution, and shows the advantage of taking full and careful histories. The patient had had frequent attacks of indigestion for which there had been given silver nitrate tablets with relief. Thereafter he had taken them "ad lib."—it is hardly necessary to add that my "cyanosis" (and, I understand I was not, the only physician who so considered it) was in reality argyria.

The following cases were seen in a self-respecting community situated 10 miles from the centre of Boston, but beyond the "one-fare zone" of the electric cars,—hence rural in character. I do obstetrics only in an emer-

gency, and I am glad to say that but few emergencies have arisen. Venereal diseases are conspicuous from the fact that, if they occurred, they were not recognized.

SURGICAL. 55 CASES.

Fractures	{ Colles 2 Olecranon 1 Rt. tibia 1 }	4
Sprains	{ Knee (with synovitis) 2 Ankle 1 Finger 2 }	5
Renal calculi—cystinuria	.....	1
Lacerations, contusions, and abrasions (One of severed tendo Achillis)	.....	24
Punctured wounds	.....	4
Foreign bodies	{ foot 1 } { hand 1 }	2
Removal hypertrophied great toe nail	.....	1
Woodchuck bite (hand)	.....	1
Septic	{ Abscess, left forearm ... 1 Furunculosis 2 Paronychia 1 Cervical adenitis (incised) (tuberculosis?) 1 }	5
Foot strain (with bunions, 1)	.....	2
Leg strain	.....	1
Sacro-iliac strain	.....	1
Acute traumatic arthritis great toe	.....	1
P. O. amputation both breasts for cancer (?) Metastases in lung (and myocarditis)	.....	1
P. O. adhesions	.....	1
Umbilical hernia	.....	1
Ruptured varicose vein	.....	1

GYNECOLOGICAL AND OBSTETRICAL. 5 CASES.

Miscarriage	.....	1
Threatened miscarriage	.....	1
Toxemia of pregnancy	.....	1
Pregnancy with gastritis	.....	1
Endometritis (with neurasthenia)	.....	1

MEDICAL. 180 CASES.

I. Respiratory tract	.....	73
(a) Mild infections of unknown etiology (including "influenza")	.....	46
Complicated by	.....	
broncho-pneumonia	.. 2	
otitis media	 2	
pyelitis	 2	
(b) Bronchitis	.....	7
with enteritis	 1	
(c) Lobar pneumonia	.....	1
broncho-pneumonia (reported elsewhere as complicating other diseases)	 3	
(d) Pulmonary tuberculosis, active	.....	2
with pulmonary hemorrhage	 1	
healed pulmonary tuberculosis	 1	
fibrinous pleurisy	 1	
(e) Smoke inhalation	.....	1
(f) Asthma	.....	1
(g) Tonsillitis	.....	8
given antitoxine	 2	
acute nephritis complicating	 1	
(h) Pharyngitis and laryngitis	.....	2
(i) Sinusitis	.....	1
(j) Cervical adenitis (not incised)	.....	2

II. Gastro-enteric tract	.....	15
(a) Gastritis	.....	4
(b) Gastritis with enteritis	.. 3	
(c) Enteritis	.....	1
(d) Constipation	.....	5
(e) Achylia gastrica	.....	1
(f) Infant feeding	.....	1

III. Cardio-renal system	.....	14
(a) Acute nephritis	.....	1
(b) Hypertension	.....	10
with chronic nephritis	9	
Complicated by	.....	
myocarditis	.....	1
angina pectoris	.....	1
cerebral hemorrhage	.. 1	
(c) Myocarditis	.....	1
(d) Functional heart	.....	1
(e) Cystitis	.....	1

IV. Contagious diseases	.....	15
(a) Diphtheria	.....	1
(b) Measles	.....	13
with otitis media	 1	
pyelitis and otitis media	 1	
broncho-pneumonia	.. 1	
(c) Mumps	.....	1

V. Eye	.....	13
(a) Conjunctivitis	.....	12
(b) Burn of conjunctiva	 1	

VI. Skin	.....	7
(a) Urticaria	.....	2
(b) Pityriasis rosea	.....	1
(c) Epidermis phyllophagialis	.....	2
(d) Poison ivy	.....	2

VII. Ear	.....	7
(a) Otitis media	.....	3
reported above as complicating other illnesses	 4	

VIII. Nerve	.....	5
(a) Epilepsy (?)	.....	1
(b) Dementia praecox	.....	1
(c) Neurasthenia	.....	2
(d) Traumatic psychosis (with hypertension and myocarditis)	 1	

IX. Miscellaneous	.....	31
(a) Eneuresis	.....	2
(b) Argyria	.....	1
(c) Undiagnosed	.....	8
(d) No disease	.....	4
(e) Measles suspect	.....	2
(f) Malnutrition	.....	2
(g) Debility	.....	1
(h) Routine examination	 4	
routine urinalysis	 2	
(i) Acute rheumatic torticollis	.....	1
(j) Myalgia	.....	1
(k) Chronic arthritis	.....	4
(l) Acute infectious arthritis	 1	
TOTAL	.....	180

Ninety-one of the above cases were seen at a boys' school, of which I have been appointed physician. All were under 18 years of age. Of the remaining, 80 were over 18 years, 49 were under 18.

I conclude from my experience, as illustrated by this table, that anyone undertaking a "near urban" type of country practice would do well to take a surgical hospital appointment, if possible, supplementing it with a Children's Medi-

cal; that while taking the latter he would do well to perfect his technique in the performance of his paracenteses. If unable to take more than one appointment, I would like to remind him that it is not necessary to be a resident interne to pick up additional knowledge in the various branches of medicine—out-patient departments give similar opportunities for less fortunately placed young men, and are anxious to procure their services.

Clinical Department.

AN UNUSUAL NEPHRITIS.

BY F. VAN NÜYS, M.D., WESTON, MASS.

MRS. A. C., aged 22, entered the Waltham Hospital July 18, 1919, remaining there 43 days. She reentered May 29, 1920, and died June 30, 1920. She was under close observation for nearly a year.

Her family history is negative except that her brother recently shows albumen in the urine after suffering for months from "indigestion." No diseases in childhood except measles. Excellent health, but for occasional sore throats, up to childbirth four years ago. No miscarriage.

Present Illness: Since her child was born, she had fair health up to the summer of 1918. Then, without ascertainable cause, she gradually developed nephritic symptoms—pallor, headaches, oedema of hands and feet, occasional nausea and vomiting, dizziness, dyspnea on exertion, and failing eyesight up to almost complete blindness. For the last six months she had suffered from paresis and partial anaesthesia of the left arm and leg. In June and July of 1919 she seemed close to death. She entered the hospital with orthopnea, anasarca, pernicious vomiting, semi-coma, partial paralysis of left half of body, and nearly complete blindness; in short, impending uremia.

Physical Examination: A small, pale, emaciated though bloated woman. Throat, tongue, and ears are negative. Teeth decayed. Skin pale. Pupils equal and react normally. Knee-jerks lively. Left ankle clonus. Lungs negative, save for moist râles at bases. Heart 19 cm. wide on percussion; action regular and rapid; sounds forcible; a blowing systolic murmur at apex transmitted to axilla; aortic second increased. Blood pressure 220/120

(this later fell and kept about 180/115). Abdomen full and soft; no masses, tenderness, or spasm; spleen not palpable; liver sixth rib to costal margin. Eye grounds showed choroidoretinitis so marked that little normal retina could be found. She could make out the form of anyone standing beside her bed.

Urine: The 24-hour quantity varied from 250 to 1500 c.c., usually about 800 c.c. Sp. gravity 1002 to 1010. Reaction acid. Sugar absent. Albumen always a heavy trace (8%). Microscopically a rather heavy sediment. Many granular, hyaline, and cellular casts. A few waxy casts. Many red blood cells, mostly shadow forms. Little fat seen. Later on in the disease the casts came in showers.

Treatment: For almost a month usual methods of treatment were tried with very little benefit. She remained in about the same condition. She was put on absolute rest, low protein (40 to 50 gm. protein daily), and as high fat and carbohydrate diet as possible. The caloric tables showed that she received insufficient food because of anorexia and uncontrollable vomiting. I believe that free daily movements of the bowels, and sweating when her strength permitted, enabled her to live through the first month in the hospital.

Caffein, diuretin, digitalis, nitroglycerin, and thyroid extract were tried at one time or another with no appreciable effect.

Finally Fischer's treatment was begun on August 16, 1919, with immediate and remarkable benefit. She received his hypertonic salt solution (sod. chloride 14 gm., sod. carbonate 10 gm., and water 1000 c.c.) daily by the Murphy drip in the rectum, and alkalies and sodium chloride freely by mouth. In the next ten days her uremic symptoms disappeared. The anasarca lessened gradually. The 24-hour quantity of urine rose to 1500 c.c. and above. The headache, vomiting and stupor cleared away. The blood pressure fell to 185/115 and remained thereabouts for many months. Appetite and digestion returned. She could sleep on one pillow and her previous dyspnea was wholly relieved. Eyesight improved so that she could read the headlines of a "yellow" newspaper, although the eyegrounds looked as bad as before.

Fischer's treatment gave so much discomfort that in two weeks the patient chose to discontinue it wholly and return home in an invalid but comfortable condition. At home she was put on the low protein diet.