speaking; yet the middle ear is normal. You cannot get him to speak the words that he has been speaking. These cases usually shut off pretty suddenly. For that reason, I think that it is labyrinthitis; because we see no evidence of middle-ear trouble in these cases when they first begin. Of course, we cannot be certain that it is a labyrinthitis; because you cannot get, in a deafmute child thus afflicted, whose other faculties are usually below the normal, the signs that we get in a grown person—nystagmus, etc. These children will not respond to these tests, unless you have been able to get them into school and train them. I bring the patient before you in order to show that something can be done in these cases. This is not a selected case. I have some patients that are better than this one.

Question—You say that eighty-five per cent of deafmutes have labyrinthitis; how do you determine that fact?

Answer—Such a statement is necessarily based upon the autopsies that have been made and reported of deafmutes. The scientific tests made on normal subjects, such as rotation, to show nystagmus, the various tuning fork tests, imbalance, nausea and dizziness, can not be determined with any degree of reliability in young deafmute subjects. Therefore, no reference is made in my paper to the usual scientific tests. I have gone through with in the deafmute children under my care.

THE SURGICAL TREATMENT OF INFECTIONS OF THE PERITONEUM WITH ESPECIAL REFERENCE TO THE IMMEDIATE STERILIZATION OF THE SAME.*

By JOSEPH A. CRISLER AND EUGENE J. JOHNSON,
Memphis, Tenn.

Barring emboli, pneumonia and a few other incidental or accidental interventions, we might say that peritonitis is the last barrier between the abdominal surgeon and a no mortality record. It is the crowning event and the last word in the warfare waged by bacteria and the superlative triumph of the enemy.

The most pregnant factors that operate as causative agents of acute general peritonitis probably are: appendicitis first, cholecystitis second, the salpingitides and other accompanying infections through the uterus third, traumatic injuries to the peritoneum and abdominal parietes fourth, and perforating ulcers of some of the hollow viscera fifth.

This will cover 98 per cent of all the causative agents in the South. Acute suppurative and gangrenous appendices stand at the head of the list, although the ratio is being rapidly reduced by early diagnoses and early operation. The so-called

Ochsner treatment instituted several years ago, while then most worthy, is now almost obsolete in most parts of the country and is responsible for the predominating number of cases of peritonitis attributable to appendicitis in the South. A large number of physicians, acting more upon the importunities of their patients perhaps, than upon their own judgment, or it may be acting upon both, are using the so-called Ochsner treatment for appendicitis and only resorting to surgery in such cases after prominent and well marked symptoms of peritonitis are well in evidence. A large number are combining the Murphy drip and Fowler position with the starvation and ice bag ideas of the Ochsner treatment, way on past the abscess walling period, until rupture of the abscess takes place and a general suppurative peritonitis results; also a great many violent, fulminating attacks of appendicitis do result in peritonitis before surgical aid can be given, even in the hands of the most skilled and careful physician, and are most frequently due to environment and inaccessibility to proper surgical measures. We think then that we are still safe in putting appendicitis at the head of the list as a causative factor.

Phlegmonous processes in the gall-bladder, an organ situated, as a certain prominent internist has said, in the region of doubt and uncertainty, is found by surgeons to cause peritonitis more frequently than has been ordinarily supposed. This, too, seems to be on the increase. We have seen quite a number of cases wherein the gall-bladder had ruptured and emptied its pus into the peritoneal cavity, having given but very little more symptomatology, outside of the blood picture, than would be expected in an ordinary case of duodenal or stomach ulcer.

In the face of all of our advanced knowledge upon the use of antiseptics and in the midst of our so-called aseptic era, our old enemy, puerperal septicemia and puerperal infections and our ever-present enemy, the Neisserian infection, continue to come up with their usual quota of fertility in the production of peritonitis.

The general run of our obstetricians do not use thoroughly boiled gloves, if gloves at all, in the handling of their cases, nor do they carry their sterilizer around in their buggies to the private homes, so as to avail themselves of sterile gowns, towels and instruments. This is partly due to the fact that the average physician is too busy to attend to these preliminaries, all-important as they are, and again to the fact that the public has not become sufficiently alive to this necessity, so as to demand it. Most of all, however, the cause lies in nature's wonderful defensive element in permitting the largest

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number of all obstetrical cases to escape infection regardless of who the accoucheur is and what he does. In other words, if the obstetrician knew that ninety-nine out of every hundred of his cases were going to become infected unless he observed the most rigid and painstaking surgical cleanliness under all circumstances, instead of the very few out of every hundred which do become infected, while the large number escape under the most careless technique, then the millennium of high class accouchement would have come.

As for the Neisserian infection we can offer no hope of its abatement. It perhaps belongs to the realm of social economics and is only an adopted child of the medical profession, under protest. There will always be enough fallopian tubes that will rupture early to give us plenty of exercise in the study of peritonitis.

Under the fourth heading we are all aware of the effects of an unattended gunshot wound or other perforations wherein a hollow viscus is injured, but we do not think we attribute quite enough importance to other traumatic injuries, such as a violent blow or kick over the abdomen, especially the kick of a horse or mule, as a productive element of general peritonitis. These cases should be investigated with the utmost care at the earliest possible moment and all of the elements of doubt should be transferred to the side of peritonitis, so that an early exploration into the abdomen can be made, for among all things surgical we do not know of anything more hidden, while masquerading under the mildest outward symptoms. Perforating ulcers permitting the outflow of the contents of the viscus into the peritoneum can frequently be anticipated, except perhaps in typhoid, and as our diagnostic skill of ulcer of the stomach and duodenum particularly, becomes more acute, these factors will diminish. So far, however, we can safely say that many of these are situated in the above mentioned region of doubt and tragedy, while many acute perforations can occur with very few premonitory symptoms.

The signs and symptoms of peritonitis are as varied as its causes and intensities, with *pain* and *rigidity* at the head of the list, while the temperature ranges are very variable. It is useless to talk about the patient's facies and the frequent vomiting and the tender distended abdomen and the pulse rate and the blood tension; while all are important, none are pathognomonic. This brings us to say that the diagnosis must depend largely upon the history of the case.

We do not mean to underrate the importance of the varying blood picture, for the microscope is of as much importance here as in the study of a case of

malaria, and the sphygmomanometer and other instruments of precision are very useful, but somehow our most active and otherwise most capable practitioners of medicine have not brought themselves to a study of these refinements in diagnosis. Whether they have been disappointed with the results or cannot spare sufficient time or do not care to trust their own findings, we do not pretend to say. We do know, however, that the largest number of cases of peritonitis that have ever fallen into our hands for surgical attention have never had a previous blood examination made. It is but fair to mention, however that the men who depend upon the bedside signs and symptoms for their diagnosis and seem to have no time and very little respect for the use of the microscope, have developed a keener mental acumen in reaching a conclusion, than those who must reach their diagnosis by set and fixed rules of mathematical accuracy. In other words, there seems to be a compensation somewhere along the line, wherein a merciful hand is extended to the man who uses what we might call the old-fashioned methods in reaching his conclusions.

Perhaps we might say that his "sixth sense" is more highly developed; yet it is a beautiful and a rare thing, to see a man in full possession of all of this and at the same time to conform to it and embrace with it, the aids given us through modern instruments of precision.

We have learned that it is only a short step between any of the infections mentioned above and peritonitis. We have learned, too, in a practical way, that the nature of the previous ailment and its intensity has much to do with the intensity of the peritoneal infection in the beginning. Many have learned the all-important lesson, that peritonitis is an unnecessary result, if these previous infections can be properly handled at the outset. The people have learned that the practitioner is at fault when he permits a case of peritonitis to develop, provided he has not been hampered by the whims of the patient or by environment. A sudden cessation of pain in the site of infection, next to changes in the blood picture, is most important. We do not have to wait for the thready pulse and anxious expression and the frequent emesis and the distended abdomen and the pain with its general rigidity. It is much better to make the diagnosis before this comes, even if in error, than to await all of the clinical symptoms, and be too late.

The treatment of peritonitis depends upon its cause and upon whether it is local or general. This is not all. The result of treatment is the most important and this depends almost entirely upon whose method you use. Murphy took a long step forward

when he instituted his saline drip, Fowler position and drainage, and the high mortality fell to a phenomenal degree, but still remains too high.

When we tell you of the treatment used first by our Dr. Eugene J. Johnson, and continually since by both of us, we expect to draw your severest fire of criticism. However, we are going to offer this as a mere preliminary report without details, as we expect to give a full and complete report including a complete study of a thousand cases at a future date.

More than six years ago Dr. Johnson began some experiments upon dogs as to the results of iodine put into and left within the peritoneal cavity. He found that large quantities did no harm. He also found that the end results of the experiments were satisfactory, in that the dogs lived in apparent good health, without discomfort and some weeks following when the peritoneum was again opened there were practically no adhesions. With this encouragement he tried the experiment in cases of suppurative peritonitis, following various infections in the person of negroes and it was discovered that if the patient was not already moribund that the mortality was reduced to nil.

He communicated this information to Dr. Crisler in a confidential way, as we had long been associated and the latter began the use of the tincture of iodine in washing out and swabbing out all pus cavities within the abdomen and pelvis, being encouraged later on to adopt the flushing of the whole peritoneum by Dr. Johnson's successes in such cases where the general peritoneum was infected or quite likely to be infected.

We subsequently found that if the tincture was diluted with alcohol to one half that the results were still satisfactory in every instance. Dr. Johnson then left out the iodide of potassium in the official tincture and used 66.2-3 per cent of the iodine salt strength instead of the original 100 per cent strength to the given quantity of alcohol. We now dilute this half with pure alcohol, which means that we use really 33.1-3 per cent strength tincture of iodine without the iodide of potassium addition as compared to the regular official tincture. Our assistants have christened this mixture "half and half," and for the want of a better name we will hereafter refer to it by this one. We have not carried this dilution with the alcohol any further down in using the agent in our work. Just how much further the dilution could be carried and still get perfect results from the iodine element or from the alcohol element, or from both, we do not know. We are, however, extending this experiment in all directions.

What we most wish to bring before you is the fact that first, we are using the above mentioned

"half and half" in all cases of peritoneal infection; whether it be localized from an unruptured gangrenous appendix or other source or whether the peritoneum is wholly infected, it makes no difference. We simply put out the fire with this mixture and disregard infection thereafter. If we have a ruptured gall-bladder, for instance, as soon as this is discovered at the operation and before the incision is extended further, we literally pour a quart of this mixture into the abdomen and thoroughly sift it into all of the recesses. We do not fear the use of too much of the mixture; our only fear is that some pocket or interspace between the coils of intestines or elsewhere might escape us. If the case is already one of acute, general fulminating peritonitis, we are even more liberal with the flushing out and washing out process with "half and half" mixture. If in our judgment a quart will do, that is all that is used, though we have sometimes used as much as a gallon. This applies equally to any other infection whether it be a ruptured appendix with its consequent peritonitis local or general or a gunshot wound or a ruptured bladder or a ruptured tube or any other infection from the pelvic organs or a perforated ulcer or what not.

The peritoneum is irrigated proportionately to the extent of infection. It might interest you to know that we have used this treatment in over a thousand cases; that it has enabled us to feel perfectly easy and contented as to the outcome of any case of peritonitis or of peritoneal infection, provided the treatment can be used before the patient is actually dying from the disease. In other words, if the toxins from the infection have not already killed the patient or rendered death inevitable, we have no further fear of the outcome, because this treatment puts out the fire immediately.

I think when all of our statistics are accurately compiled we will show a mortality, even in diffuse peritonitis, of less than 2 per cent. We will also be able to show a comparatively painless convalescence. We will also show fewer adhesions than would follow after recovery from the peritonitis under ordinary methods. We will also show that there is no toxicity from the use of the treatment. We will also show that from within six to eighteen hours there is a drop of temperature from whatever it was to beneath a hundred degrees. We are enabled by this method to boldly and safely remove every appendix that is suppurating and has ruptured, even though in doing so we have to tear down the abscess wall. We are also enabled to remove with perfect confidence and safety any infected tube or evacuate any broad ligament or pelvic abscess or infection, regardless of the nature of the infection and of its duration. We are en-

abled to handle gunshot wounds of the intestines, in so far as the fear of subsequent infection is concerned, with all safety.

You will please pardon us for digressing, but this holds good in all infected joint effusions and infected pleural effusions. We have also applied it in a very few cases of local infections of the meninges.

As to the subsequent handling of the cases, we will say that if the infection has been very extensive in the peritoneum, for instance, we use the same methods of drainage and all other precautions, including the Fowler position and in desperate cases hypodermoclysis. We usually mop out all of the surplus fluids that are accessible to the incision after the mixture has been liberally poured into the abdomen. We are prepared to say, however, that as much as a pint of the mixture, and probably much more, can be left in with all safety and without any subsequent ill-effects, provided drainage is used. Just how much of this mixture or of alcohol or of the pure tincture of iodine could be poured into a normal peritoneum and be left there without evil effects we do not know, but we believe that very much could be used with safety.

In conclusion, we wish to apologize for this abrupt and scattering report, and while we invite your severest criticism, we feel perfectly easy over the outcome of the treatment, because we feel fully assured that if you will adopt this treatment carefully and fairly, that your judgment will ultimately be overwhelmingly in favor of it.

We feel honored to have had the pleasure of giving this report, even in a feeble and scattering way, first, to our Southern Medical Association.

DISCUSSION.

Dr. W. A. Bryan, Nashville, Tenn.—This report is an exceedingly interesting one to me. I have been using iodine sometimes in the abdomen recently instead of carbolic acid.

For instance, in dealing with the stump of the appendix, in dealing with abscesses that have occurred or for which we have directly operated.

Now, we know that iodine is toxic. We know that Dr. Crisler would not dare to give one of his patients a bit of that mixture to drink, because we would be sure that that patient would die of poison. On the other hand, we know that these patients that the doctor has treated did not die; therefore we assume that they did not absorb the poison.

It is interesting in the study of inflammatory processes generally—I am not talking about those cases like gunshot wounds, where you get to the patient immediately and can apply your iodine and kill the infection outright, but I am talking about those cases where an inflammatory process has gained a footing. What is an inflammation? We have been taught, and we have been thinking all the time until in recent years, that inflammation is a pathological

process. Now, we do not look at inflammation as a pathological process at all, but as a healing process. Inflammation is the thing that nature does to limit the spread of the bacteria; it is the thing that nature does to kill the bacteria, to heal the damage or to cure the damage done by the infection.

In an infection in the peritoneal cavity the bacteria are buried in the tissues. Now, in peritonitis the bacteria do not lie on the surface. I am not criticising the doctor's statement; I am simply trying to get at the *modus operandi* of the treatment. The bacteria do not lie on the surface as they do in gunshot wounds, where some one has probably carried in a lot of bacteria. They lie not on the surface, but in the tissues. That inflammatory process develops; your bacteria are lying here (illustrating); how deep depends upon the extent of the inflammatory process or infection. That means simply that the iodine does not come in contact with the bacteria that are playing the mischief, but it kills these on the surface (illustrating on board). Now, what does it do? What does anything that has ever benefited an inflammatory process do? We used to use antiseptics, you know, on an inflammatory process. We found out that it did as well without antiseptics. An inflamed hand, for instance. We soaked another inflamed hand in hot water; the second one gets well just as readily as the first one. So that certain things are done in the treatment of inflammatory processes. We cannot get at the germs and kill them; neither can we kill those in this process that has taken place. In the inflammatory process the resistive powers of the body are interfered with, and the anti-bodies, though they may be high and abundant in the blood where all this exists, those anti-bodies are not as they should be. Now, if we can get rid of the poisons contained in here we will save the patient from so much absorption of the toxins. If we can bring in the serum a new circulation with abundant leucocytes that are capable of using the opsonic power in the blood on these bacteria, then we get something worth while.

What does the iodine do? Comes in contact with the surface. You would not dare give a patient a teaspoonful of tincture of iodine, yet we do not hesitate to pour a quart into the peritoneal cavity, and it makes the cavity weep.

I was glad to hear you say you drained in these cases, doctor. The fluids are poured out on this surface and new fluids are brought with high antibacterial powers into the peritoneum, and thereby you accomplish two things—get the poison directed away from the center of the fight and bring the curative properties here.

Iodine cures inflammatory processes the same as Bier's hyperemia does, and that is successful because he was the first man who understood the treatment of inflammation—to get rid of the poison—bring in the thing that nature provides to kill the bacteria and cure the patient.

Dr. J. Shelton Horsley, Richmond, Va.—This treatment of Dr. Crisler by extensive flushing of the peritoneum with iodine is entirely new to me, though, of course, we all use iodine in sepsis very freely. It certainly seems like heroic treatment, but, after all, results are the thing; and if Dr. Crisler can cure his patients with this treatment that could not otherwise be cured, then we should adopt this method. Personally, I recall one case mentioned by

Dr. Wyeth in which death followed the injection of a drachm of tincture of iodine into the sac of the hydrocele. This would make me a little cautious in using iodine so extensively in a serous cavity.

Dr. Jere L. Crook, Jackson, Tenn.—I feel that we are under obligations to Dr. Crisler for this startling report, which I was somewhat prepared for because I had known of Dr. Johnson's pioneer work along this line some months ago. The only tribunal before which we can judge of the results of any treatment is at the bar of mortuary statistics. With this point established, the doctor's treatment has certainly made good. Whether startling or not, it is extremely interesting to us, because it is new, not the use of iodine in infections, but the use of iodine in the delicate structures of the abdominal cavity, and from the fact of its newness it becomes startling.

I was glad to know that Dr. Johnson, preliminary to his use of iodine on the human subject, had demonstrated its harmlessness on the lower animals, because it would have required a high degree of bravery to have used it first in the human system without knowing what it would do. From the lower animals he seems by gradual gradations on the negro race to have worked up to the ordinary fellow-citizens. (Laughter.)

I shall look forward to the completion of the report, and I feel sure it will give me a great sense of pride from the fact that two of our own Southern men, so closely identified with Southern surgery and ideals, have been the pioneers in this wonderful work.

Now, we begin to ask ourselves, "How can these things be?" that are so different from the things of the past.

Dr. Bryan's theory was interesting to me, but I have another one: I do not believe the use of iodine in an infection could possibly be a prototype of Biers' theory, because we have already the highest inflammation we could possibly have—a temperature of 105—and there could not possibly be a greater infection locally; hence nature is already doing her very utmost there to prevent the death of the patient by the bringing forward of her white blood cells to ward off the army of invasion. You cannot increase in this case the number of white or red blood cells coming forward by the use of iodine. What do you do, then? Simply kill out numbers of the invading germs there, and by killing out the enemy you give the victory to the white blood cells. That seems to be the way we can theorize on it in a case of septic peritonitis, but whenever he pours it into a fresh gunshot wound we have no protection from nature. She has not had time to marshal her forces, the septic contents are poured out over everything, and you have a condition absolutely normal, of the intestine and peritoneum, if you operate immediately. Now, I believe in that case the throwing out of the iodine gives nature a chance to bring forward her germs of defense to ward off the invading germs.

But, theorize as we may, the results speak for themselves, and I feel very much gratified that the doctor has brought forth this report; and it seems to me there is a note of hopefulness we have not had in the past, because we have not reached the point that we would like to reach, and many of us have not had the remarkably successful experience with Dr. Murphy's technique that Dr. Murphy has

had, and so we welcome anything that will give anything like the results which the essayist has given us today.

Dr. Duncan Eze, Nashville, Tenn.—Mr. Chairman, I do not desire to add anything of a scientific nature to the subject, but when Dr. Crisler was speaking of the heroic treatment with iodine, and, further, Dr. Crook added that the experiments were made in regular gradation, it reminded me of the introduction of ethyl chloride some years ago, in which we thought we had at last a safe anesthetic.

We began by making some experiments ourselves, and, in fact, had an assistant to use the ethyl chloride—first upon dogs. It seemed to be very satisfactory. Then, later, upon the colored race, which seemed also very satisfactory; but I suggested we had better go a little further. So this experimenter of ours then used it next on an Irishman (laughter) and said it was all right; and we then proceeded with ethyl chloride indiscriminately and thought we had an ideal anesthetic—which we did when its use was for only a short time.

I desire to state that if nothing else had been presented to this section, I am fully repaid in hearing this interesting paper on the use of iodine, for my trip to Jacksonville. Dr. Crisler's experiments in the use of this most excellent drug are of great value, and we learn something more unique and interesting about it—absolutely curative—each and every day.

Dr. E. Denegre Martin, New Orleans, La.—Dr. Crisler speaks of one thousand cases. How many of this number were cases of general peritonitis and what were the results? In local peritonitis we know that drainage will always give good results, but it is in cases of general peritonitis where Murphy's suggestions have been so valuable, and in which we have been able to save many of the cases which were formerly looked upon as hopeless, that we are most concerned; I would like to ask Dr. Crisler how many of these cases were among those of which he speaks and what were the results?

Dr. Bryan—I just want to speak about the misunderstanding Dr. Crook had of my position. I was not giving theory. That is a demonstrated fact. Now, you can chop all you please with your axe, but if you don't hit the chicken you don't cut off his head. You can go out in the woods and shoot all you please, but if you don't hit the bird it flies on. Now, you are a thousandth of an inch to an inch and a half from the surface, and if you don't hit the germs you cannot kill them. We are discussing a fact.

Now, I stated another fact: We know that when these irritants are applied to the surface of the peritoneal cavity they produce a pouring out of fluid into the peritoneal cavity. I do not say that they loosen up the circulation in the inflammatory area, but everyone knows, in the midst of stasis, that not all the vessels are involved, and every inflammatory process that produces extensive stasis produces gangrene. If your fluids are poured out on to that surface, where do they come from? From the tissues underlying the surface. Now, if there are tens of millions in this inflammatory process, where are those fluids replaced from? From the circulation going on, because it is replaced. Where do those blood vessels get those fluids that the iodine causes

to weep out here? From the general circulation. Nature carries an inflammatory process by doing certain things, and Dr. Crisler is doing the same thing that Bier did. What did Bier do? Went into the field where he could get good soldiers and good medicine to pour on to the bacteria—namely, into the general circulation. Dr. Bier does it one way, Dr. Crisler another, but in the end the results are the same.

Dr. Crisler (closing).—Mr. President, I am very much obliged to the gentlemen for their very kind consideration of the subject. I am surprised at their mildness. I thought they were going to get really violent, but they are all as calm and genteel as is their habit in the ordinary walks of life.

I don't think any of us know just exactly what happens. I am inclined to think that the peritoneum is sterile when we get through with it, through and through. I don't know what absorption may take place, or what effect this absorbed stuff may have on the toxines and on the germs that are extant in the body—the lymphatics and even the blood in some cases. I do know that the condition becomes improved almost immediately. It seems to us that every hour we can see an improvement. We cut into the bellies frequently and find gangrenous appendixes and yellow water, and you can drain and do everything else, except use iodine, and once in a while they will die.

As to the Murphy drip, of course my friend, Dr. Martin, knows that I am too wise a man to throw any rocks at Dr. Murphy about anything. I think he is one of the greatest teachers of the age and a great man; but if Dr. Martin has tried very diligently to make those people who are almost dying of peritonitis, either before or after operation, hold and absorb that water, he is doing more than I have been able to do. We quit that a while ago, because they are the kind who need the saline most and absorb less. Give them a hypodermoclysis. Now, just take this much home with you: If you are afraid of iodine, don't use it at all, to commence with, but if you have an idea that there may be some element of truth in it, do this: Take the next four cases or five cases that you have which you know, by all your previous treatment, they would die, and apply this treatment vigorously and liberally to them and to those that you know are going to die under ordinary circumstances, and see how few you lose, see how quickly the patient rallies, how quickly the pain disappears. If you operate this afternoon, in the morning the patient is better and smiling, flat abdomen, pulse fuller.

Question.—How do you drain?

Dr. Crisler.—By just common drainage tubes and Fowler position.

Now, I believe it does sterilize the peritoneal membranes through and through, turns it dark all the way through, cauterizes the lymphatics and prevents rapid absorption for several days, and you get fewer adhesions.

Don't try it on cases that you know are going to get well, but try it on some of the cases that you feel are going to die. It won't cost much, and you will be using it the next time we hear from you.

Of course, we have not had a thousand cases of suppurative peritonitis in our lives, and I trust we never will, but we use it in every case that is infected. But we always drain.

CORRESPONDENCE

REGARDING THE PREVALENCE OF GONORRHOEA IN THE NEGRO—AN INQUIRY.

Editor Southern Medical Journal.

The following extract from an article "The Negro and His Health Problems," by Dr. J. Madison Taylor, appearing in the *Medical Record* of September 21, 1912, has excited a degree of unfavorable criticism from different sources, which contend that the imputation is not fair to the Negro race: "An important observation made by several Southern physicians is to the effect that sexual lawlessness resulting in lynchings is to be explained thus: The male negro is nearly always infected with gonorrhea. He neglects treatment habitually. Chronic prostatic irritation ensues. Thus sexual impulses frequently become overmastering. Alcohol particularly inflames this state and likewise dethrones reason; hence the first female he meets he is tempted to assault. This is often a white female; thereupon the fury and vengeance of white men are excited, and disastrous results follow to the negro."

The idea of the comparative prevalence of gonorrhea in the race is a generally accepted statement among medical men of the north, but I have been unable to verify it by any statistics or other authoritative sources. May I ask you to bring the matter editorially before your subscribers, asking for contributions on the subject. An answer to the following questions may be of assistance in getting at the pith of the matter.

In your personal medical experience as compared with the white race:

1. Is gonorrheal urethritis more prevalent among the adult negro male population?
2. Are its sequela pyosalpinx, pelvic abscess, etc., more common among the adult female negro population?
3. Is the proportion of gonorrheal ophthalmia greater among the negro newborn?
4. Is the disease more prevalent among the city or country negro population?
5. Is the disease as virulent in the colored race?
6. Is chronic gonorrhea and its sequela, gleet prostaticitis and seminal vesiculitis more prevalent in the negro male?
7. Is this condition responsible for the sexual lawlessness mentioned in the previous quotation from the article of Dr. Taylor?

Realizing that you will appreciate that fairness and not prejudice is instrumental in instigating the above inquiry, I hope that you through your *Journal* will assist us in answering the question.

Very truly yours,

WM. A. STEEL, M.D.

330 N. Broad St., Philadelphia, Pa.

The above inquiry is worthy of respectful attention by Southern physicians, those of both town and rural practice. They should be answered from the records of personal observation, and without a tinge of bias. They are questions that should be answered. The columns of the *Journal* are open for a discussion of the subject.