Clinical Department.**AN EXPERIENCE WITH CASCARA.**

BY RICHARD F. CHASE, M.D., BOSTON.

In a recent case of gastric ulcer I prescribed Ext. Cascara Sag. Fl. (P. D. & Co.), directing the patient to take 15 to 20 drops before each meal and to diminish the dose as the bowels became regulated. At the next visit the patient reported that the medicine had not materially influenced the actions of the bowels, that even teaspoonful doses had caused only slight evacuations, moreover, she said the medicine was not as bitter as I had given her to understand. My suspicions were aroused as to the product she was using, so requested her to bring to me the bottle and its remaining contents. On its receipt, I at once discovered by the taste and odor that the preparation was not the one I had prescribed. I had the same prescription filled at another druggist's and the desired result was obtained. Assuring myself in so far as possible, that substitution had been practiced in the case of the original prescription, I wrote the pharmacist accusing him of substitution. He at once denied the accusation and brought to my office the stock bottle from which the prescription had been filled. The bottle bore the proper label, but by comparing its contents with samples of the true product the druggist was soon convinced that something was wrong. Assuring him that his preparation was practically an inert one he left the bottle with me.

With the assistance of a representative of P. D. & Co., it was discovered by the number on the label, that the bottle of fluid extract of cascara had been put up by his firm in 1888, eighteen years previously. What preparation of cascara the bottle contained at this time could not be learned, but as cascara does not deteriorate with age, as I understand, the most natural conclusion is that sometime in the past another than the original product had been poured into the bottle. The mutual understanding between the druggist and me is that he unintentionally substituted.

This experience explains how in an unusual way an inferior product may be substituted for a good preparation.

My experience with and confidence in the preparation prescribed has led me twice in the past two years to the detection of practically worthless preparations of cascara. I have often heard physicians state that they do not obtain results with this drug (but many more that they do); the reason I have found at times is that either a good fluid extract was not used or else the drug was not properly administered. In the cases in which a laxative is indicated (and the number is far less than is generally supposed if other measures are properly carried out) I have found no drug so generally beneficial as a good fluid extract of cascara, when given in small doses three times a day before meals. The same amount given in less frequent doses will not produce the same results.

Medical Progress.**REPORT ON THE PROGRESS OF SURGERY.**

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(Concluded from No. 18, p. 500.)

THE MANAGEMENT OF CERTAIN CRITICAL CASES OF INTESTINAL OBSTRUCTION, WITH REPORT OF CASES.

JOHN W. ELLIOT,¹⁰ in a very interesting paper on this subject, read before the American Surgical Association in July, 1905, gives the following summary:

(1) We find the prevalent method of enterectomy with immediate suture in cases of intestinal obstruction attended with a high mortality, due to the changed condition of the distended bowel.

(2) Enterostomy with later enterectomy is to be reserved for the cases unable to bear primary enterectomy.

(3) Enterectomy with a temporary artificial anus should be the operation of choice in all critical cases of intestinal obstruction, where there is an opportunity for resection, whether it involves the large or the small intestine.

(4) The suggested improvements in the technique are as follows:

The upper distended bowel should not be opened until the peritoneal cavity is completely closed. (This is already the practice of several surgeons.)

The open ends of the bowel should be stitched together on their mesenteric side before they are fastened into the parietal wound. This will greatly facilitate the later closing of the artificial anus.

When the artificial anus is in the small intestine, the partially digested discharge from the upper opening should be collected and injected into the efferent opening.

(5) The closing of the artificial anus is a safe operation, and hardly disturbs the convalescence.

(6) Up to the present time not enough cases have been done by this method to estimate its relative mortality, but the cases here reported, with those referred to, suggest the probability of better results than have been obtained by enterectomy with immediate suture.

THE TREATMENT OF DIFFUSE SEPTIC PERITONITIS.

Le Conte,¹¹ after a brief experience with the method advocated by Murphy in the treatment of diffuse peritonitis, is impressed with its value. He states that Murphy's technique may be ranged under six headings, as follows:

"(1) The rapid elimination of the cause of the peritonitis, whether it be a perforation of the bowel, a gangrenous appendix, a ruptured pus tube, etc. This must be done with the least possible handling of the peritoneal contents.

"(2) Drainage by tube of the lowest portion

¹⁰ *Annals of Surgery*, November, 1905, p. 668.¹¹ *Ibid.*, February, 1906, p. 231.