

of cases claims influenza as its cause and that the latter in some cases expends its force upon the appendix.

I am, Sirs, yours faithfully,

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*To the Editors of THE LANCET.*

SIRS,—Appendicitis has of late years become so general that individual opinion as to the probable cause and prevention should be of interest to the readers of THE LANCET, and in behalf of public health and of common humanity I venture to address this communication to you. The lowering of the tone of the large intestine through the habitual use of purgative drugs is to my mind a very great factor in causing appendicitis. A very large number of persons are apt to indulge over freely in the delicacies of the table and at the same time take an insufficiency of exercise and consequently resort is too often made to a habitual use of purgatives to prevent the effects of an overloaded system or to relieve constipation. With the large number of purgative drugs and quack medicines in the form of tablet, pill, or syrup, offered to the public the desired effect is easily obtained, for if one purgative tablet, pill, pilule, or syrup should prove ineffective another form can at once be resorted to without a thought for the ultimate future result. The drugs which are used in the compounding of such tablets and quack medicines are, for the most part, aloes, aloin, and cascara sagrada, all with a well-defined action, principally upon the large intestine, causing increased peristalsis. Senna and rhubarb are also akin in their action to the above-mentioned drugs and are also used to stimulate intestinal movement. Purgatives of this description must enervate and break down the tone of the bowel by repeated and frequent use. The constant resort to enemata must also have a like effect.

It is well known that purgatives lose their efficient power after a time of continued use and larger and larger doses or stronger and stronger drugs have to be resorted to, for the intestine becomes habituated to the requirement of a stimulant to enable it to perform its duty, even as the habitual drunkard requires increased potions to fit him to face his duties. There can be no doubt that progressive atony of the appendix takes place *pari passu* with that of the colon and the appendix being a rudimentary organ and a *cul de sac*, suffers more from the effects of atony than the rest of the intestine, which has a considerable driving power, so to speak, behind it. The appendix is not able to expel its contents, faecal accumulation and concretion take place, and gaseous distension arises from decomposition of its contents and in course of time an attack of appendicitis occurs. Of course, the essential point is to establish such a habit of daily evacuation that there may not be accumulation of the noxious waste. Now, how is this to be effected? Most certainly not by the constant use of drugs which act upon the colon for the reasons I have stated above, as atony or degeneration due to over-stimulation may be engendered. If purgatives must be resorted to then the use of saline laxatives should be adopted, as their mode of action is to disturb the process of osmosis, bringing about an increased flow of secretion, rather than to stimulate peristalsis. The action of saline purgatives by disturbing the process of osmosis and causing an increased flow of water from the intestinal vessels into the cavity of the bowel brings about an increased liquidity in the stools. The salines are also absorbed by the blood vessels and partly carried into the general circulation and partly again excreted into the bowel by the intestinal glands, the result being a liquid stool in which peristalsis does not play an important part.

If drugs are used which increase peristalsis the appendix partakes in the general action and the habitual use of such drugs brings about atony and degeneration and the appendix loses power in emptying itself; but if saline laxatives, which disturb the process of osmosis, are resorted to the vessels and glands of the mucous lining of the appendix act in conjunction with the other intestinal vessels and glands, causing a watery flow, and consequently the flushing out of the appendix takes place. Have not saline purgatives been recommended in certain stages of appendicitis? Is it not good treatment for a patient suffering from chronic constipation to persist in the use of saline laxatives even to the verge of diarrhoea and in order that the lost tone of the bowel may be brought back to combine such laxatives with strychnia, or

nux vomica, or iron, or belladonna? For habitual constipation, instead of aloes, aloin, cascara sagrada, and quack aperient medicines which for the most part contain these drugs, are there not plenty of saline aperients which can be effectively used by the public in a general way?

To summarise, the increase in cases of appendicitis is due to the growing habitual use of such purgative medicines as cascara sagrada, aloes, and aloin, which relieve constipation and empty the intestine by peristalsis, thereby causing loss of tone with all its concomitant symptoms, the remedy being—if drugs must be resorted to—the use of saline laxatives which disturb the process of osmosis and do not lower the tone of the bowel but act by causing an increased flow of intestinal juices.

I am, Sirs, yours faithfully,

FREDERICK W. ALEXANDER,  
Medical Officer of Health of Poplar.  
Public Health Offices, Bow-road, Bow, E., Sept. 18th, 1905.

## THE MEDICAL MAN, THE CORONER, AND THE PATHOLOGIST.

*To the Editors of THE LANCET.*

SIRS,—I have read your annotation on the above subject in your issue of to-day and entirely agree with it. During the 28 years I have been coroner I have made it a rule to have called as witness the medical man who first saw the dead body. Both the reasons you give for this rule are well worthy of consideration.

I am, Sirs, yours faithfully,

A. F. VULLIAMY,  
Coroner for Suffolk.  
Ipswich, Sept. 16th, 1905.

*To the Editors of THE LANCET.*

SIRS,—Among the "annotations" in THE LANCET of Sept. 16th is one in connexion with a recently held inquest in the south-western division of London, which you conclude with the observation that "this case is another of those to which Mr. Troutbeck's *excuse* that special skill is needed in some cases in order to elucidate the cause of death can in no way apply." The word (which I have ventured to italicise) is happily chosen, for as it appears to me (and many other coroners) much excuse is needed before the line habitually taken by Mr. Troutbeck can be justified. There are many cases which form the subject of an inquest in which it becomes necessary to summon the assistance of an expert analyst to make a reliable investigation of the contents of the stomach, the bowels, or the blood. Would this afford an "excuse" for summoning such an expert witness in every instance? The contention would be absurd and is it not equally absurd to pretend that because an expert *pathologist* may be *sometimes* needed such should be *always* called? Surely the average medical practitioner who has obtained his diploma or degree, not without a stiff examination in pathology, may be trusted as fully as any specially skilled pathologist to conduct an ordinary post-mortem examination in order to establish (say, after *physical* injury) whether death was caused by the rupture of some important organ, fracture of the base, gun-shot wound producing hæmorrhage and shock, strangulation, foreign body in the larynx, or cut throat, and, say, after suspected natural causes, cardiac, pulmonary, hepatic, cerebral, or other internal mischief? But, further, it appears to me (and to many other coroners) that Section 21 of the Coroners Act of 1887, subsection 1, distinctly *implies* that the medical officer called in "*at his death*" should, in the first instance at all events, apply to those who first had the opportunity of seeing "the deceased," whether immediately before or after the last breath was drawn seems immaterial, for otherwise the words that follow would be devoid of meaning: "If it appears to the coroner that the deceased person was not attended *at his death*," then the coroner *may* summon "any legally qualified medical practitioner," &c.

However this may be, it has fortunately long been usual for the police to inform the coroner what medical man (if any) had recently before or "*upon the occasion*" of his death visited the deceased and equally customary for the coroner, in the absence of any special reason to the contrary, to summon such medical man as a witness. No medical coroner can entertain any doubt as to the propriety of this; the position and surroundings of the body, the *state* of the body at the moment of inspection, the presence or absence

of ephemeral signs which may have vanished before the "expert pathologist" can be obtained, all point to the value of the *earliest* medical witness on the scene being the one most likely to supply the needful information. And, curiously enough, in another column of THE LANCET this very week is to be found an instance bearing strongly on the point,<sup>1</sup> in which you say: "And it would have been concluded that he met his death by drowning had not the fact been noted by the medical witness that the eyelids were closed when the body was discovered." If the "medical witness" had been Mr. Troutbeck's "skilled pathologist" (who would have had no opportunity of seeing the deceased till he received Mr. Troutbeck's order to make a post-mortem examination) this fact could scarcely have been "noted by the medical witness"—but it is needless to multiply examples. Mr. Troutbeck's view of the coroner's "excuse" is doing yeoman service for the medical profession, and the constantly increasing numbers of medical practitioners who are selected by the county councils (in preference to legal gentlemen) to fill the important office of coroner bear witness to the growing recognition among the educated classes that nine times out of ten "the medical cause of death," which it is the first duty of the coroner to investigate, is best performed by one who can interpret the technical terms, often *necessarily* made use of by the medical witness, to a jury of average British laymen.

I am, Sirs, yours faithfully,

Sept. 19th, 1905.

MEDICAL CORONER.

PS.—I hope you will not think it presumptuous if I add (after reading your article on two cases of recent inquests, the one in South Staffordshire and the other in Lancaster, under the heading "Medicine and the Law") that in my opinion neither would the view that "it was idle to suggest insanity" have been expressed in the one, nor an order for exhumation been publicly called for in the other, had the respective coroners been members of our profession. For in the one the letter laid before the jury would have contained ample evidence to the medical mind of the insane condition of the writer at the time; and in the other I fancy that if the Home Secretary had been (privately) made acquainted with the facts it does not seem unreasonable to think he might not have insisted on exhumation, provided no criminal responsibility had been suggested at the preliminary investigation before the deceased coroner and his jury. Is it conceivable, for example, to take another instance, that the Home Secretary in these days of preventive medicine would censure a coroner who should excuse his jury (of 12 or 15 fathers of a family may be) from viewing the body of a child whose violent death (during tracheotomy, for instance) had revealed the fact that death was due to disease of an eminently infectious character, such as diphtheria? The consequence of an inquest having been held without "the view"—when ample evidence of "identity" is forthcoming—is that the inquest may be "quashed." What reasonable ground for "quashing" can be discovered if no criminal liability had been brought home to anyone by the verdict of the jury?

## ANGINA PECTORIS AND ALLIED CONDITIONS.

To the Editors of THE LANCET.

SIRS,—On two points arising out of Dr. T. Oliver's lecture on this obscure subject, published in THE LANCET of Sept. 16th, I desire, with your permission, very briefly to remark. One of these concerns the now well-recognised work of another. I am aware that in a lecture it is not possible to deal with matters historical at any length, but the omission of some names is as inexcusable as the production of *Hamlet* with the melancholy prince left out. After reference to the fact that arterial thrombosis may be attended with pain, Dr. Oliver quotes Charcot's interpretation of these phenomena and his introduction of the term "intermittent claudication," as possibly explaining angina pectoris in some cases. That this is a feasible hypothesis, possibly correct in some cases of an affection which may be symptomatic of many conditions, I am not at present concerned either to deny or affirm. The point I would refer to is that this interpretation was advanced as a brilliant suggestion nearly a century ago by Allan Burns of Glasgow, who must

in justice be allowed to have anticipated later writers in advancing the occlusional theory of angina pectoris and whose name one would have expected to transpire in this connexion. In his little book, still so valuable because filled with observations culled at first hand from nature, he deals sufficiently fully with the subject.<sup>1</sup> The explanation was then hypothetical and it is no more now, but to Burns belongs whatever credit there may be in having advanced it.

The other point I refer to less willingly, because it is distasteful to call attention to one's own work. Dr. Oliver, like most writers on this subject since Edward Jenner's day, discusses the question of coronary calcification in relation to angina pectoris. The occasional association of these states is, of course, incontestable. No less incontestable is their frequent dissociation. Quite as incontestable to my mind is the fact that the subject has not been investigated in such a manner as to lead to any definite conclusion on the point. The minute microscopical examination of such vessels in these cases has rarely been undertaken, judging from the reports of necropsies, and they occur quite sufficiently often, both in private and in hospital practice, to have afforded opportunity for such examination. In one of a series of lectures on Cardiac Pain, which I delivered from the same rostrum as that from which Dr. Oliver gave the lecture under discussion, I related some particulars of a case of this kind which occurred in my clinic at the Great Northern Central Hospital and in which I was able to determine what was, to my mind, a significant fact whatever its value. My lectures were fully published, with illustrations, in THE LANCET of Nov. 1st, 8th, 15th, and 29th, 1902. The patient had frequent attacks of angina and died in one of them. The necropsy revealed calcareous arteries, a portion of which I decalcified and numerous sections of which I examined microscopically. Some of these, fortunately, cut across a small intravascular aneurysm in the neighbourhood of which there was a nerve ganglion and neuritic fibres which appeared to me to be an explanation of the very frequent attacks of angina which the patient exhibited both when recumbent and when erect. I carefully refrained from being dogmatic in asserting a necessary connexion between these states but confess that no other condition seemed to me to explain the situation so well and I took it as a type of a condition which has admittedly more than one basis. Whether I was correct or in error in doing so can only be decided by a similar examination of calcified coronaries in cases both associated with, and free from, angina pectoris. So far as I know, my case at present stands alone.

I am, Sirs, yours faithfully,

ALEXANDER MORISON, M.D., F.R.C.P. Edin. & Lond.  
Upper Berkeley-street, W., Sept. 17th, 1905.

To the Editors of THE LANCET.

SIRS,—In the course of his interesting and instructive remarks in THE LANCET of Sept 16th on the treatment of angina vera Dr. T. Oliver states that of all drugs that give relief there is none that can compare for immediate action and efficacy with nitrite of amyl, while in some cases of angina vera nothing short of the administration of morphine or opium will give relief. There is one drug which compares favourably with nitrite of amyl in the treatment of angina pectoris and that is chloroform. The inhalation of chloroform removes the strain from the heart by vasomotor dilatation of the arterioles much more safely and effectually than does nitrite of amyl. Moreover, chloroform has none of the disadvantages of nitrite of amyl and as it abolishes pain almost immediately neither morphine nor opium is necessary. The inhalation of chloroform need not be pushed beyond the stage of unconsciousness and, unless the heart is actually failing, it always gives complete relief.

I am, Sirs, yours faithfully,

Harley-street, W., Sept. 19th, 1905. EDWARD LAWRIE.

## THE CONDITION OF THE BLOOD VESSELS DURING SHOCK.

To the Editors of THE LANCET.

SIRS,—I agree with Mr. J. P. Lockhart Mummery that a full discussion of our divergent views on this subject would take up more of your space than we can hope for, but I should like to be permitted to reply to his letter in your

<sup>1</sup> THE LANCET, Sept. 16th, 1905, p. 842, The Eyelids after Death.

<sup>1</sup> Observations on Diseases of the Heart, &c, Edinburgh, 1809, p. 138.