

was as to whether physicians shall testify after death of the patient, as in cases of testamentary capacity, insurance cases, etc. If it had been always strictly interpreted it might cause some inconvenience and the court of appeals of New York has admitted that it might cause mischief.

In Indiana in a similar case the court held that the legal representative of a patient might waive the privilege.

In the people *versus* Kennuder, 119, New York, 585, it was held that the privilege does not extend the information as to the patient's condition, either mental or physical, gained by the doctor who is sent to make an examination of the prisoner's mental or physical condition in jail, provided the testimony does not include conversations with the prisoner or transactions in jail. If the doctor simply testifies as to his opinion of a person's mental or physical condition as he saw him in his cell or court room the evidence is unobjectionable.

In Michigan several cases have been argued upon the question whether if the patient states a certain physician attended him the physician can be put on the witness stand to contradict the patient as to this fact.

In *Brown versus Metropolitan Life Insurance Company*, 65 Michigan, 306, this was not allowed.

In New York, it has been further decided that if a party claims to exclude evidence as coming under this prohibition he must show the relations of a physician to the patient to have existed, and that the rule does not apply to criminal cases. Moreover, the courts have seemed to rule that it is not needed to definitely prove the information to have been necessary to enable the physician to act as such, this being inferred by the relation of physician and patient. Furthermore, the rule of evidence which excludes communications between physicians and patients must be invoked by an objection at the time the evidence of the witness was given.

The penalty of the disclosure of confidential communications appears to be regulated by the general law. Bishop on Rights and Torts, 1889, Sec. 295 and 301 gives the spirit of the law as follows:

"The doctrine that one who follows a command or permission of the law, is not liable to another, casually injured thereby, furnishes a wide protection to defendants in libel and slander. But this principle covers in general only honest and careful utterances. Sec. 295.

"We may add as the doctrine here to be considered, that whenever the law or any social duty which the law recognizes, permits or requires an utterance not thus privileged absolutely, it is conditionally so, that is, if cautiously and circumspectly made so as not to inflict needless injury, in other words, if it is honest and without malice—otherwise it is not protected."

As illustrations are given: A letter written by a man to his wife's mother, cautioning her against one she contemplated marrying, was in an English jury case, ruled by Alderson B. to be privileged (*Todd versus Hawkins* 8, Car and P. 88). But in a Massachusetts case (*Joannes versus Bennett*, 5, Allen 169) a like letter from a pastor to a girl was ruled otherwise as he was not related to her. See also in N. Y. *Byam versus Collins*, 39 Hun. 204.

It is not likely that any court would rule a communication or consultation for criminal purposes to be privileged. In New York this has been specially

ruled against. *Hewitt versus Prime*, 21 Wend. 79. *Hageman on Privileged Communications*.

I am very glad the Medico-Legal Society of Chicago, composed as it is of representative members of the medical as well as of the legal profession, has taken up the consideration of this important question, and I believe they fully agree with me that the State of Illinois should as speedily as possible be placed in the role of States that makes the communications of physicians, lawyers and clergymen privileged communications, and we sincerely trust, at least, that there is no medical man in this association who would not prefer to sacrifice his personal liberty rather than violate the secrecy or implicate the character of his patients and under no circumstances permit professional secrets to be dragged into publicity in a law court.

A RAPID AND SUCCESSFUL TREATMENT OF HERPES ZOSTER.

Read in the Section on Dermatology and Syphilography, at the Forty-seventh Annual Meeting of the American Medical Association, held at Atlanta, Ga., May 5-8, 1896.

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Although herpes zoster is one of the effects of the skin which is of comparatively frequent occurrence and has been known ever since cutaneous eruptions were observed, there is no manner of doubt that many points connected with its etiology and pathology are still veiled in more or less obscurity. It was not until quite recently that a consensus was arrived at in regard to its being a relapsing disease. And, for this knowledge we must give the general practitioner due credit. Without any pretenses to a special knowledge of cutaneous medicine, the country doctor has frequently had occasion to observe "shingles" occur a number of times in the same individual. Such instances have been reported so often that the idea no longer prevails that one attack of herpes zoster confers immunity against subsequent attacks in the same individual. Nevertheless, this was the opinion formerly held by the best observers and a reference to works on dermatology will show that it was generally accepted. The cause of this no doubt lay in the fact that the patient either did not apply for relief when another attack came on or sought the services of some one else in the hope that this latter would be able to prevent a recurrence.

Another idea which has prevailed is that the disease has a self-limited course, lasting from three to four weeks, when spontaneous recovery takes place. I have seen cases in which successive crops of vesicles have appeared for two or three months with breaking down of the lesions and ulceration. Not only this but the ulceration would become phlegmonous and during all this time the neuralgic pains were of an intense character, to such a degree that opium and other sedatives soon became impotent. Such a self-limitation is certainly one not to be desired and therapeutic interference is not only indicated but imperatively demanded by the exigencies of every case.

It has been asserted by some good authority that no treatment will cut short the course of herpes zoster and that the best which can be expected from medication is to diminish the neuralgic pain. This is far

from being either satisfactory or encouraging; and it would certainly be positively discouraging to those who have occasion to treat that dread condition—zoster ophthalmicus. For it has been too often the case that an inability to arrest the process has resulted in perforation of the cornea and, not infrequently, destruction of the globe. When the conjunctival surface is not attacked we are told that herpes zoster of the fifth nerve invariably leaves scars to mark the former location of the lesions, a dictum, which, to my mind, is a *non-sequitur*. It is based on the fact that active interference has not even been attempted under the fallacious idea that the disease must be left to run its course. I have always been in the habit of treating these cases rather energetically and my efforts have been awarded by excellent results. Whether it has been merely a coincidence that such a short period of treatment was followed by recovery, or a peculiar circumstance that all were cases that would have recovered spontaneously in a few days I shall not stop to discuss. The fact remains that a similar treatment in a number of cases was eminently satisfactory and I shall continue to use it until a sufficient number of failures declare themselves to demonstrate its inefficiency. In principle, the method has nothing new to recommend it; in its application, however, it is characterized by some details, which will recommend it for simplicity and ease of administration. The following are a few cases which occurred in my private and hospital practice, and which will serve to illustrate the points I wish to make.

Case 1.—Charles W., photographer by occupation, aged 32, is of robust physique and is a prominent and active member of a gymnasium. He exercises daily but is inclined to take on adipose tissue. Some few days before I saw him he conceived a notion that his liver, bowels and other internal organs were not "working right." In order to remedy what he conceived to be his generally bad condition he made a concoction according to the formula furnished by some kind friend. An examination of the receipt showed it to contain a very large amount of colchicum. As a result of the ingestion of this mess the patient was violently purged and a repetition of the dose made him very feeble indeed. The third day after taking the mixture an eruption of herpes zoster declared itself. As soon as the vesicles appeared a slight itching and a marked neuralgia were manifest. The next morning I saw the patient and the distribution of the eruption was about as follows: Anteriorly, a patch of pin-head sized vesicles about $1\frac{1}{2}$ by 2 inches in size was located over the third intercostal nerve at a point corresponding to about the center of the clavicle. Posteriorly, the eruption followed the course of the same nerve extending from about five inches to the right of the spinous processes of the vertebrae to the margin of the trunk and with an almost uniform width of 2 inches.

The treatment ordered was to take thrice daily, after meals, the following pill:

R. Acidi arseniosi	gr. 1-20	003
Pulv. piperis nigris	gr. ij ss	15
Ext. gentian	q. s.	
M. Ft. pil. No. 1.		

These were ordered to be taken for ten days.

Externally: campho phenique powder liberally sprinkled upon absorbent cotton and applied to the eruption. This dressing was to be repeated twice daily. In three days crusts had formed and, on the fourth, the case was at an end, the neuralgia having completely disappeared.

Case 2.—James C., a druggist, 36 years of age, presented himself for treatment of an intercostal neuralgia of the right side. He complained of a marked neuralgic pain which had preceded the eruption some five days. It was not the intensity of the pain that the patient complained of but the fact that the eruption was spreading. At the time I saw him the outbreak consisted of a number of patches of the size of a silver quarter dollar distributed over the area supplied by the sixth intercostal nerve. It extended from a point about six inches to the right of the median line posteriorly and about four inches from the median line anteriorly. The vesicles were well-formed and, in many places, two or three had coalesced.

This patient was placed on the same treatment as Case 1, and in five days the cure was complete. He was ordered to continue the pills for two weeks longer in order to avoid the possibility of a recurrence of the trouble. Up to the present no reappearance of the trouble has manifested itself.

Case 3.—Winston W., aged 17, a buggy-boy in a livery stable appeared at my clinic with the statement that the eruption showed itself a week previously. There was no neuralgia experienced before the eruption appeared; but when it did manifest itself neuralgic pains were felt. The eruption appeared over the tract of the fifth intercostal nerve. Five patches were present to the left and below the left nipple, three below the left scapula, one being very small. The patient is of a highly nervous temperament, a slight tickling almost throwing him into convulsions, making him jump about in a grotesque manner and grasp anything or any one within reach and strike the object or person with his fists. At the stable where he worked he was constantly subjected to this nervous excitement and this may have acted as a causative factor.

The following treatment was ordered:

R. Acidi arseniosi	gr. 1-30	002
Pulv. piperis nigris	gr. j	06
Ext. gentian	q. s.	

M. Ft. pil. No. 30.

Sig. One pill after each meal.

Externally:

R. Pulv. camphoræ	3ij	8
Bismuthi subnitrat	3iv	16
Cretæ preparat	3j.	32

M. Sig. Apply twice a day.

This powder was ordered spread on cotton as in the other cases and six days after the inception of the treatment the patient was cured. No new vesicles formed subsequently, the pain had disappeared and no new attack has manifested itself since.

Case 4.—Lydia C., a school-girl 9 years of age, has had recurrent attacks of herpes zoster every year. She is a blonde, but appears well nourished. She has recently suffered from imitative chorea but is now well of that trouble. Her nervous system, however, is very susceptible to shocks of all kinds. The present attack is the most severe she ever experienced. It appeared some four days before she came to the clinic. A large patch of closely aggregated vesicles was located on the left and posterior side of the neck. Other patches occurred on the left shoulder, upper part of the left arm over the area supplied by the musculo-spiral nerve. The neuralgia was intense, being worse at night. The child showed plainly the intensity of the neuralgic affection. There was no zosterian fever present nor any history of such. It would hardly exist in view of the fact that a marked neuralgia was present.

The treatment in this case was the following:

R. Liq. kali arsenitis	3ss	2
Vini ferri		
Syr. limonis	āā 3jss.	48

M. Sig. Teaspoonful in water after each meal.

Externally: The same powder was used as in Case 3. On the sixth day the pain had all disappeared as well as the eruption and there existed but a very slight superficial desquamation. The patient was subsequently seen and the favorable condition continued.

Case 5.—Oscar M., a laborer 64 years of age, applied at my clinic two days after the eruption had declared itself. No antecedent trouble or present discomfort could be elicited beyond constipation. No neuralgic pain was present nor had any been felt and no medicines had been taken. In fact, no neurotic basis could be discovered as a possible cause of the eruption. This latter consisted of a vesicular eruption, such as is characteristic of herpes zoster, extending along the level of the right twelfth rib from a distance of about two inches from the posterior median line, over the abdomen, up to the umbilicus. The vesicles were well marked, rather large, but with no tendency to coalesce. The only subjective symptom complained of was an intense burning sensation at the site of the eruption. The treatment ordered consisted of the following:

R. Liq. kali arsenitis	3vj	24
Vini ferri		
Syr. limonis	āā 3ijj	96

M. Sig. A teaspoonful in water after each meal.

Externally: Campho-phenique powder was liberally dusted on cotton and applied to the eruption twice daily. Five days after the treatment was begun the eruption was all dried up and three days later no vestige of it remained. The patient was ordered to continue the internal medicine until it was all

taken and strictly enjoined to present himself should any new symptoms show itself. He never reappeared.

Case 6.—Daniel F., an engineer 36 years old, appeared four days after the eruption had occurred. About two weeks previously he was treated for diarrhea. He had been drinking alcoholic liquors freely. His diarrhea subsided in two days and he was constipated. The eruption consisted of isolated patches of vesicles over the tenth and twelfth ribs on the right side of the back. He complained of some itching and of a neuralgic pain on the anterior portion of the trunk. As the patient expressed it, "the pain stops at the middle line." The eruption had an irritated appearance.

The treatment ordered was the same as in Case 5. Three days later some of the lesions were well, no new ones having appeared. Five days later the pain was much less the lesions disappearing. Ten days after presenting himself the patient was practically cured.

Such is a brief outline of cases of herpes zoster seen by me in July, 1895. I have purposely chosen these, as the time which has elapsed since then has been sufficient to arrive at a positive conclusion as to whether the attack was definitely cured in each case. It will be interesting to note whether recurrences take place or not. So far I have noted none and I have been careful to keep them under observation. What concerns us more directly is in reference to the treatment and I desire to incorporate in these views some experiences noted before and after the treatment of the cases which have been outlined above, more especially as regards some of the generally followed practices. The cases which have been recited certainly sufficiently demonstrate that the opinion that herpes zoster can not be cut short in its course is a fallacious one and will not be referred to at any length.

Some few points which will be noted in connection with the cases outlined are that, in the first case, arsenious acid seemed to act better than Fowler's solution. I have found that the Asiatic pill is, on the whole, the best method of administering arsenic and its use may be prolonged for a much longer period of time than the Fowler's solution. Furthermore, I have never seen any untoward symptoms follow the administration of arsenious acid, whereas the solution has produced arsenical dermatitis in a number of cases, notably factitious zona pectoralis. A point which I have always observed has been to give a sufficient dose and I am certain that it is owing to this fact that attacks of zona were aborted in such a short time. An examination of the histories of all the cases given will demonstrate the short time required to relieve each one and furthermore that this period was shortest in those who took the Asiatic pill. Certainly, the time was very short and the neuralgia ceased when the eruption disappeared.

The local treatment which I have employed is one which has always acted favorably with me. Protection is afforded by a cotton dressing and a rapid disappearance of the eruption by means of a drying, analgesic powder. I have essayed lotions, collodion, plasters, and similar methods but never found any one equal to the old and time-tried powder. Another fact which I have observed is that the vesicles do not break down, no ulceration occurs and consequent scars do not result from an attack.

While the treatment I have outlined is both rapid and successful, it possesses another advantage which, in my opinion, is not the least valuable. I allude to its simplicity. It may be carried out by any practitioner of medicine; it requires no special, rare, or costly preparations, and can be easily understood by any one. It might be said that its very simplicity is its greatest objection in the eyes of those who look

upon dermatology as a mysterious science instead of what it really is—cutaneous medicine.

Before closing these remarks I desire to call attention to the fact that the most difficult thing to determine is the cause of herpes zoster. While in some of the cases given, a neurotic base apparently existed, in others no such history could be elicited. So far as parasitism is concerned I never could satisfactorily establish it nor do I remember that any one has succeeded in doing so positively. That a neurotic element exists, however, is beyond doubt, in view of the constant presence of a neuralgia or some very marked pain which disappears simultaneously with the eruption.

CASE OF ACUTE CIRCUMSCRIBED EDEMA OF GOUTY ORIGIN.

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This paper is presented with a view to call attention to an etiologic factor which has apparently escaped the notice of writers on the subject of angio-neurotic edema.

Quincke, in his original and classic article (in the *Monatshefte für praktische Dermatologie*, i, No. 5, 1882) cautions against confusing acute circumscribed edema with that of menstrual, malarial and arthritic origin. It has sufficient points of difference in gross appearance from these types, but as regards causation it can not be discriminated from the edema occasioned by these three causes. Matas has reported a case of malarial origin in which the periodicity of the attacks was marked. Osler asserts that the disease may be hereditary through many generations and mentions a family in which five generations were affected, including twenty-two members. Milroy of Omaha described cases of hereditary edema, in which there were twenty-two individuals in six generations. The cases could scarcely be appropriately called acute, as the edema was solid, affecting one or both legs and existed from birth.

Alcoholic excesses, gastro-intestinal disturbances (Elliot, Quincke), mental excesses, fatigue, grief, traumatism, ingestion of certain articles of food, as fish, apples, etc., have been cited as causative factors. In the latter instances the disease shows a close affinity to urticaria. The disease is regarded as a vasomotor neurosis, by which the permeability of the vessel walls is greatly increased. The latter, which is the view taken by Quincke, does not agree with the theory advanced by Unna of spasm of the muscular coats of the veins in explanation of urticaria, the giant form of which greatly resembles angio-neurotic edema. So long as the nature of gout remains unknown, the connection of it with the case in point may be alone explained by hypothesis. The theory held by Cullen is expressed by Duckworth as: "There is a diathetic habit which is expressed in, 1, a neurosis of the nerve centers, which may be inherited or acquired; 2, a peculiar incapacity for normal elaboration within the body, not merely in the liver, in one or two organs, of food whereby uric acid is formed at times in excess or incapable of being transformed into more soluble or less noxious products." This would bear upon the point of the neurotic origin of angio-neurotic edema. If, further,