

There is a strong probability that a large percentage of all cases of insomnia in the insane can be relieved by judicious chloralamid exhibition, particularly if attention is paid to accompanying conditions and general physiologic treatment is adopted at the same time. To merely impute the sleeplessness to brain disorder and give a hypnotic without reference to the condition of the heart, liver, kidneys, or emunctories generally, would be extremely irrational, and would fully account for failures in some instances. At times I have found that the insane patient would be affected differently by the same dose from no discoverable cause, but where proper attention has been paid to the general bodily condition, as a rule, good results were secured with chloralamid.

In delirium tremens, it is only common sense to see that elimination is carried on properly, and often eliminants alone will end the furor of alcoholism.

In some of the congestive attacks of paretic dementia, ergot if anything, would prove more useful, but paretics will secure sleep from chloralamid ordinarily, as well as other patients.

I have found it useful in the sleeplessness and painful cerebral states of melancholia, and particularly so in the case of one recurrent melancholiac whose relapses were cut short by the prompt action of the drug.

In cerebral and spinal syphilis, pain is assuaged markedly by chloralamid, but of course it should not be given where there is a stuporous tendency, nor with expectation of anything but amelioration.

In the traumatic neuroses it is particularly valuable. Several cases of Erichsen's disease from concussion of the spine were enabled to secure sleep from chloralamid when ergot, massage and hot water applications which had previously been helpful had failed.

If the small doses of chloralamid, when substituted for bromid of potassium, are found to be generally applicable, I do not believe that ill effects can follow from the abuse of the chloralamid in this way, at all comparable to what has been experienced in the wretched overdosing of the bromids. At least the anemia and mental hebetude produced by bromids will be escaped from by the substitution. And how far these small doses of chloralamid can be properly used remains to be ascertained, but my experience has been satisfactory enough to lead me to continue their use in many of the nervous affections where irritability or pain are prominent.

There is such a thing as the chloral habit, which is much more readily stopped than the opium addiction, but whether it is too early to assert that there is or is not a chloralamid habit, certainly nothing denoting any liability to habituation has been prominently mentioned, though so far as that is concerned any drug that proves serviceable in continued suffering may be used too long, and the only question of concern is what undesirable consequences may come from such prolonged use. If chloralamid is a reconstituent hypnotic there can be no such bad effects following its over-indulgence as are recorded against opium and chloral.

It would be folly to expect that any single remedy for insomnia would be available in all instances, for just as sleepless states may be caused by any of the multitude of maladies to which the body is liable, so must there be numerous appropriate measures of relief,

when relief is at all possible. The advice to seek and remove the cause of the sleeplessness is sensible enough, though in too many instances the cause is only conjecturable. Nevertheless, a rational system of hypnotic use can be secured on a physiologic basis, and with far more satisfactory results if we duly regard the cause of the loss of sleep and existing bodily conditions. For example, a dose of ergot in some hyperemic states may relieve pain or cause sleep by lessening the vascular tension upon which these disabilities depended. A hot bath may distribute the circulation and act derivatively upon organs which, when congested, caused the distress and wakefulness. Massage acts similarly when scientifically applied, and when unskillfully made use of may add to the discomfort; for example, if derivation from the head is set up by massage it will relieve cerebral hyperemia, but add to cerebral anemia, so this method must be resorted to with full knowledge of the physiologic results aimed at.

In a general way, we may classify hypnotic action as accomplished by derivation, such as by removing irritative quantitative causes; by elimination of quantitative or qualitative causes, as of some toxic agent; reconstructive action by resupplying parts in states of defective nutrition; sometimes by minimizing activity until rehabilitation can overtake waste with supply; by restoring normal function as with digitalis or alcoholics. The least desirable of all methods being such as merely stupefy and overload the circulation with effete or poisonous material through interfering with elimination, or by destructive changes induced in nerve tissues or the blood upon which the nerves depend for sustenance.

So eliminative functions should be kept in good repair, if possible, when almost any kind of a hypnotic is given, particularly such as are likely to add some toxic material to the system; but the ideal sleep procurer would be one that abstracted nothing from the nervous system that it contained normally, nor added thereto anything deleterious; and as sleep is a process of repair or feeding of the nerves and their ganglionic centers, still more effective would be whatever caused sleep by repair of such waste; and unless credible evidence to the contrary appears in the course of time, we are in possession of such a hypnotic in chloralamid.

## "CAN TYPHOID FEVER BE ABORTED?"

A FEW ADDITIONAL CASES, THEIR PROGNOSIS AND TREATMENT.

Read before the Mahoning County Medical Society, Feb. 12, 1894.

BY JOHN ELIOT WOODBRIDGE, M.D.

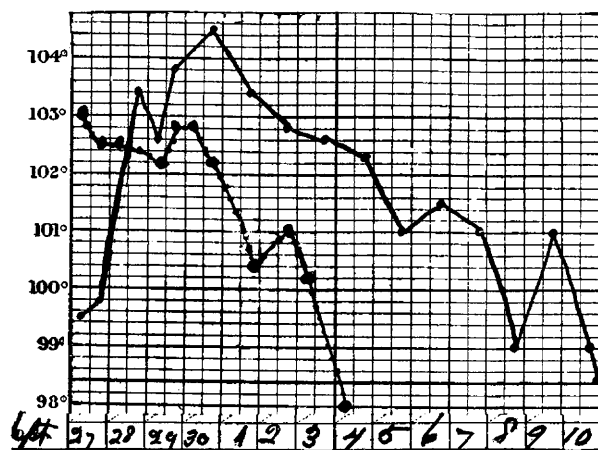
YOUNGSTOWN, OHIO.

[Continued from page 187, Feb. 10, 1894.]

In my last paper, published in the current issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, I concluded the history of my cases with No. 41, John Holland, and with a promise to report the case of his brother, Ralph Holland, together with six or eight other cases under treatment. Some of these cases recovered without having developed pathognomonic symptoms of typhoid fever, and consequently can not be reported as such.

Case 41—is especially interesting. I was not aware until several weeks after his recovery, that his attending physician, a personal friend of mine, after having made a diagnosis of typhoid fever, had been discharged and myself sent

for, although I *did* think the family unusually inquisitive; and answering questions I gave a diagnosis of typhoid fever and a prognosis of ten or twelve days sickness—no danger. On the seventh day of treatment when the rose spots were abundant and other symptoms well marked I asked Dr. Thomas, one of the best diagnosticians in our Society, to examine him and make a diagnosis; he did so and said: "Doctor, that is typhoid fever, and I will sustain you in that diagnosis at any and all times;" and added: "My experience with cases of this character is that recovery is slow and tedious." I said: "Well, I shall ask you to come here in two or three days to see a case of *aborted* typhoid fever." I said further: "Doctor, would you dare to give this man solid food?" "If he were my case I certainly should not," he said. Turning to the man I warned him of the opinions held by the best thinkers of the profession, and then asked him if he would be willing to eat a piece of beefsteak. He said: "Yes, if I told him to." He ate the steak without ill effects and on the ninth day I asked Dr. Thomas to reexamine him when his temperature was 97°. He was discharged cured on September 28. His brother, Case 47, residing with him, was taken sick September 29. Pulse 100; temperature 103°. Tongue, severe headache and other symptoms characteristic; later, petechia abundant; dullness over spleen well marked. After treating him five days I wished to be away at the meeting of the Mississippi Valley Medical Association and the World's Fair, and asked Dr. McCurdy, a member of our Society, to take charge of him together with Cases 43 and 44 which he did continuing my treatment, so that in all these cases I had the advantage of his valued confirmation of my diagnosis. Temperature normal twelfth day.



Cases Nos. 43 and 44. Diagnosis, typhoid fever. Names, F. G. and Mrs. F. F. Date of admission, Sept. 27, 1893.

Case 45—was diagnosed by the attending physician, confirmed by counsel called from a neighboring town and after ten days I was sent for with the statement that little hope was entertained of his recovery. In five days his temperature was normal and recovery was rapid and complete. Oct. 31, 1893, Dr. J. J. Thomas who had seen the result of my treatment in two or three cases, telephoned me that he had a typical case of typhoid fever to which he would like to have my treatment applied. Examining the case, No. 49, I expressed the opinion that this was one of more than ten days' duration, that there was but a limited area involved, and that it was bordering closely on the stage of ulceration. He recovered in eighteen days.

Case 50—presented well-marked and characteristic symptoms. (Recovery followed by alopecia.)

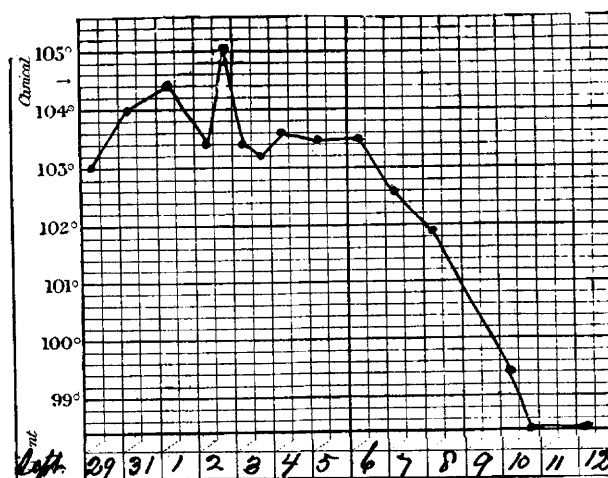
Cases 40, 46 and 48—are excluded from the estimate, because they recovered before a positive diagnosis was possible, as is also Case 42, because there was unquestionably ulceration of Peyer's glands before I was called.

Case 51—In the evening of Jan. 22, 1894, I was called to see Angus McFee. Examining him I said: "This man has had typhoid fever more than two weeks." They said: "Yes, he had a chill two weeks ago last night." The next morning I took Dr. McCurdy with me. We failed to get his morning temperature, which the night before had been 105½°. He was voiding both urine and feces involuntarily, teeth, gums and lips covered with sordes which his faithful nurse, his wife, was unable to keep cleared away. His bowels were intensely tympanitic; in short, all symptoms characteristic.

I hand you his chart to show the result of treatment during the first few days, which since has been far from satisfactory and the end is not yet. On returning from my first visit to McFee on January 22, I found a gentleman waiting to have me go to 221 Belmont Avenue to see Willis Hume supposed to have typhoid fever. He had been with his mother who was nursing her brother through a five weeks attack of the disease. His symptoms were well marked. Dr. Barnes examined him and confirmed my diagnosis. I hand you his chart, No. 52. Shortly afterward his brother, Guy Hume, was taken sick with symptoms of the disease. Pulse 112, temperature 104, but recovered before a positive diagnosis could be made.

On February 6 I was called to 940 Shehy Street to see Thomas Murdock, living within a few rods of McFee, his helper in the mill, and his friend and nurse during his present sickness. His symptoms were characteristic and indicated the beginning of a very severe attack of typhoid fever. His chart, No. 55, shows the result of treatment to the present time. After visiting him two or three times I told him he had typhoid fever, would be able to sit up and eat solid food in a few days. That there was no danger of his being as sick as his friend, or of dying. Dr. Robert D. Gibson, our last President, visited this case and confirmed the diagnosis.

Case 43—Frank Vogelbarger was a rather severe case of typhoid fever. I had attended his brother through an attack of the same disease some time before, from which he made a most satisfactory recovery. However, I did not keep a special record of his case.

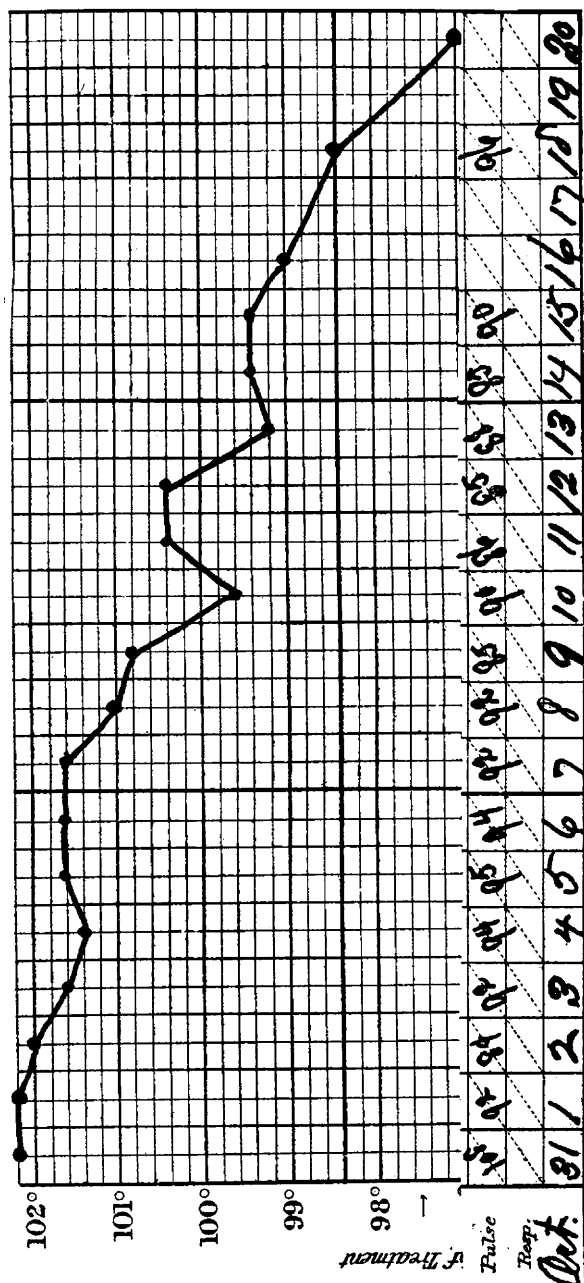


Case No. 47. Diagnosis, typhoid fever. Name, R. H. Date of admission, September 29.

With the exception of one patient who was dying when I was called, in consultation with the attending physician, and one other who had been sick thirty-five days, and recovered, and a few doubtful cases who recovered before a positive diagnosis was possible, these are *all* the cases of typhoid fever I have seen since my last paper was written. They round out more than twelve years of active work without a death in my private practice from this disease, while my brother practitioners are having no better average results than in former years, when my death rate was so high. Accept them for what they are worth, as additional evidence that my claim that typhoid fever can be aborted, and that the life of every uncomplicated case of typhoid fever can be saved is a valid one. That this claim will be hotly contested, no one familiar with the most recent literature on the subject can doubt.

What a contrast when compared with my personal experience during the first sixteen years of my practice, which amply justifies the editorial quoted in my last paper, when my death rate was enormous, and the average duration of illness of those who recov-

ered, as accurately as I can estimate it, was more than thirty-four days. As these estimates are made from memory aided by very insufficient data, the accidental omission of some of the milder cases may make both death rate and duration of disease too high. But giving myself the benefit of every doubt, and excluding the large percentage of those who died, the estimates show that those who recovered did so after more than a month of sickness that must have left their constitutions fearfully shattered. They

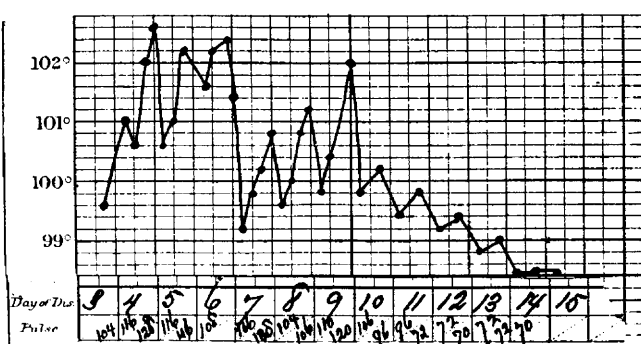


Case No. 49. Diagnosis, typhoid fever. Name, W. S.

recovered, too, probably more in defiance than as a result of treatment; a sad commentary on sixteen years of careful and conscientious work according to the best light obtainable from any text-book within my reach at that, or at the present time, as far as internal medication is concerned.

Do not understand me to state that the result of treatment during all of those sixteen years was equally bad. In 1876 a new light began to dawn on

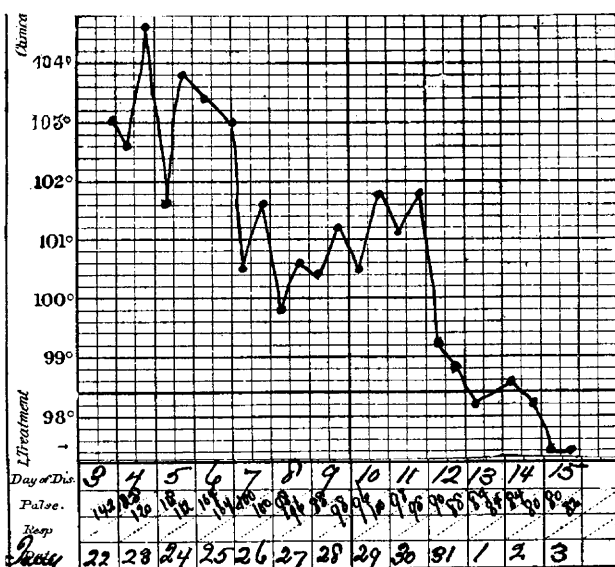
me, and during the following seven years to the beginning of 1882, when I had my last death from typhoid fever, my results were manifestly better, not alone in a greatly reduced death rate, but also in a great shortening of the average duration of sickness. In 1880, believing myself in possession of valuable knowledge on the treatment of typhoid fever, which ought to be given to my brother practitioners, I availed myself of the opportunity offered by a paper on the subject read in this Society by one of



Case No. 50. Name, B. C. W. W.

its ablest members; after criticising the paper in most unmeasured terms, I gave my own theories, and was much chagrined to find myself standing entirely alone in the advocacy of a method of treatment which, though crude indeed, had yielded to me most excellent results as compared with my earlier experiences.

Years passed, and in 1891 another paper on the same subject was read in this Society, advising a



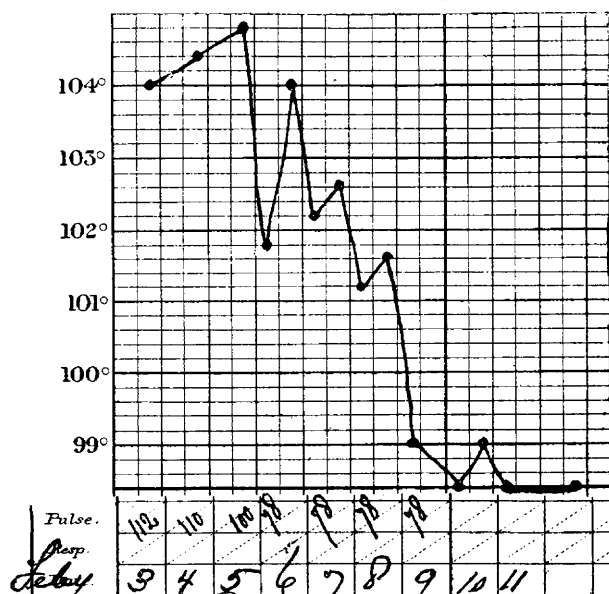
Case No. 52. Diagnosis, typhoid fever. Name, W. H. Date of admission, Jan. 22, 1894.

course of treatment only a little worse than the one I had so mercilessly criticised eleven years before. In criticising this last paper, after showing why its recommendations were not only unwise but absolutely dangerous, and driving its author to the refuge of the high authorities he had copied, and to the further statement that he had advised the remedies I had condemned as dangerous in *small* doses only; I said that I had long believed typhoid fever to be due to a germ having its earliest habitat in man in the ali-

mentary canal, and that when a germicide powerful enough to destroy the germ without detriment to the patient, could be brought in contact with it, that the problem of the abortive treatment of typhoid fever would have been solved, and that I believed the means of doing this were already at our disposal.

The questions now are, what are they, and how are they to be brought in contact with the germ they are intended to destroy, and what other object, if any, are we to seek to accomplish that we may most speedily restore our patients to their normal condition of health.

I must confess myself at a loss how to approach this part of my subject; admitting that the germ enters the system most frequently with the water and food taken into the stomach, finds lodgment there and multiplying, finds its way into the small intestines and further. I conceive that he will treat typhoid fever best who best measures the condition of his patient, or rather the extent of territory over which the germs have spread and the amount of mischief already done, and having done this, to select and apply his remedies in such manner as to most speedily stop their



Case No. 54. Diagnosis, typhoid fever. Name, D. N.

ravages and most effectually relieve the patient of the ptomaines, tox albumens, injuries to Peyer's glands or other ill effects of their temporary sojourn. This is a much too difficult task, I fear, for me to undertake to-night. Some time in the future I hope to give expression to my views on these points, but at present I think I can do no better than give the treatment of two or three typical cases, in connection with their bedside histories.

Case 51.—A. McF., (whose chart you have), as stated before, had been sick sixteen days when I was first called; his temperature was  $105\frac{1}{2}$ ; his bowels intensely tympanitic; he was voiding both urine and feces involuntarily. During the first two days he took about 60 minims eucalyptol, 15 minims guaiacol, 30 minims turpentine, and perhaps 15 grains of the following mixture:

No. 1.  
 R Podophyllin, . . . . . gr. i.  
 Hydrarg. chlor. mitis. . . . . 3i.  
 Guaiacol carb. . . . . 5 vi.  
 Thymol . . . . . 5 v.  
 Menthol . . . . . 5 i.  
 Sacch. alb. . . . . 3 ii.  
 Eucalyptol, (as much as possible).

M. In very minute doses every half hour to one hour.

During the following three days, he took  $2\frac{1}{2}$  minims guaiacol and 5 minims eucalyptol every three or four hours all of the time, and part of the time double that quantity with an occasional 10 drop dose of turpentine added; and in addition small doses of quinin continuously every three hours; occasionally a  $2\frac{1}{2}$  grain tablet of Dover's powder. Nearly every day during his sickness, and sometimes twice a day, he had rubbed on his abdomen a mixture of eucalyptol and guaiacol, with the addition, sometimes, of turpentine. His kidneys failing to respond to the turpentine, there was given him a diuretic as follows:

No. 2.

R Potass acet. . . . . 3i.  
 Spir. nitri. dulc. . . . . 3ss.  
 Aquæ dest. q. s. ad. . . . . 3iv.

Sig. One teaspoonful every half hour in water or lemonade.

And when the bowels became constipated "glycerin suppositories" were used. Whisky, milk, eggnog and Fairchild Brothers and Foster's panopepton were given freely. This is the first and only case in which I have ordered thorough and systematic sponging, in my own practice, during the past twelve years; and I did so in this case only because he came under my care on the sixteenth day of his sickness.

Case 52.—W. H. took R No. 1 two days in about  $\frac{1}{4}$  grain doses every thirty minutes.

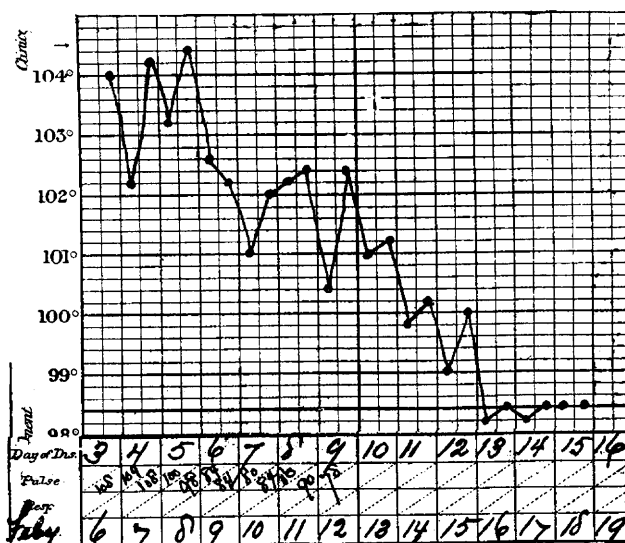
For two days:

No. 3.

R Eucalyptol. . . . . 3ss.  
 Spir. rect. . . . . 3i.  
 Guaiacol . . . . . 3ii.  
 Aquæ dest. q. s. ad. . . . . 3iv.

Sig. One-half teaspoonful every three or four hours.

For one day, No. 1; No. 3, two days; No. 1, one day; then No. 3 until the temperature had been subnormal two days.



Case No. 55. Diagnosis, typhoid fever. Name, T. M. Date of admission, Feb. 6, 1894. Diet: Ate beefsteak on eighth day, beefsteak and blanc mange on ninth day, and whatever food he desired thereafter.

Case 55.—T. M. took No. 1 two days; eucalyptol and guaiacol, two days; No. 1, one day; eucalyptol and guaiacol in one mixture, and thymol in another to the present time. (Feb. 12, 1894.)

This was practically the course pursued with the cases reported. I should have much preferred giving exact rules for a general course of treatment, applicable to every case, but do not feel competent to do so; nor do I know how much medicine has been given in any case because I never wrote a prescription for any of these preparations, but have always carried them with me and I poured out a sufficient quantity to last a day or two and when exhausted replenished it from my case. Since I see my dilemma, however, I shall leave a definite quantity and in a future paper

write more concisely; and yet I fear it will ever be a difficult thing to lay down fixed rules by which to treat such a disease as typhoid fever, in which the symptoms of the disease constitute a very imperfect criterion by which to measure either its duration or gravity, and almost none for treatment. While my cases may have been too few to establish the value of my theory of treatment, they have been too many and the results have been too good to admit of longer silence on my part.

Thus far in my private practice I have had no death from typhoid fever for twelve years. I have been able to abort two or three cases when first seen on the tenth day, and *all* who came under my care on or before the eighth day of sickness. It may not be possible to abort every case, beginning on the eighth day, nor is it necessary, for when the profession and the people understand that typhoid fever can invariably be cured when proper treatment is instituted at a sufficiently early period, the physician will no longer wait until his patient is covered with petechia, or has had one or more hemorrhages before making a diagnosis or beginning treatment.

In conclusion, I beg the gentlemen to understand that in criticising these papers by Youngstown physicians I wish to cast no slur upon my brother members of this Society. Their work was neither better nor worse than the teachings of the most learned members of the profession. I believe that the members of this Society are the peers of an equal number of the members of the profession in any spot on the globe. And when I invite criticism of my claims here, I feel that I am standing before a tribunal that would quickly find errors, if there were errors to be found.

### OPERATION FOR THE RELIEF OF VALVE-FORMATION AND STRICTURE OF THE URETER IN HYDRO- OR PYONEPHROSIS.

BY CHRISTIAN FENGER, M.D.

PROFESSOR OF CLINICAL SURGERY, NORTHWESTERN UNIVERSITY MEDICAL SCHOOL AND CHICAGO POLICLINIC, CHICAGO.

In all cases of pyonephrosis we may expect to find some obstruction to the flow of urine either in the renal pelvis, the ureter, the bladder or the urethra. If the obstruction is external to the ureteral opening in the bladder, the pyonephrosis is double; if on one side, the obstruction must be in the ureter or the pelvis of the kidney.

Lumbar nephrotomy for pyonephrosis has a mortality of 23.3 per cent., and primary lumbar nephrectomy a mortality of 34 per cent. (Tuffier.)<sup>1</sup> Secondary nephrectomy must be made to close the fistula after some time has passed, but this should not be delayed until amyloid nephritis of the other kidney has set in. The mortality from this operation is low, 5.9 per cent. If we add the 5.9 per cent. mortality from secondary nephrectomy to the 23.3 per cent. mortality from primary nephrotomy, the total of 29.2 per cent. is still 7.8 per cent. less than the mortality from primary abdominal nephrectomy,

<sup>1</sup> A word of caution about guaiacol and eucalyptol. Many of the specimens of both, obtained from highly reputable houses are wholly unfit for administration. In my earlier experience I had some very unpleasant results, especially from eucalyptol, much of which is inert and some absolutely poisonous. I have a dozen or more samples in my office now, all obtained from the best sources, and yet one-tenth of an ordinary dose of some of these would act as a most violent emetic. I believe guaiacol carb. to be the best of its class.

which is 37 per cent. and 4.8 per cent. less than the mortality from primary lumbar nephrectomy, which is 34 per cent. Consequently, in pyonephrosis, nephrotomy is the operation of choice. (Tuffier.)

The disadvantage of nephrotomy as compared with nephrectomy for pyonephrosis is that a fistula remains in 45 per cent. of the cases. This means that after a time a secondary nephrectomy must be made. Fistulas remained in 34 per cent. of the cases of calculous pyelitis and in 54 per cent. of the cases of non-calculous pyelitis. The smaller number of fistulas in calculous pyelitis is, to be accounted for by the fact that in a certain number of these cases, the stone prevents the passage of urine, and with the removal of the stone, the obstruction is removed. Where there is no stone, simple nephrotomy will leave the impediment in all cases. If in both calculous and non-calculous pyonephrosis we can reestablish the permeability of the ureter, we may expect to materially diminish the percentage of permanent fistulas.

Tuffier, in the discussion of pyonephrosis, in his excellent monograph on surgery of the urinary organs remarks: "It would be interesting to know the condition of the ureter, the strictures, bands, valve-formations that transform an open pyelonephritis into a temporarily closed hydro- or pyonephrosis. As yet these investigations for the intermittent pyonephrosis have not been made."

#### VALVE FORMATION AND BENDING AT THE PELVIC ORIFICE OF THE URETER.

Valve formation and oblique insertion of the ureter was first noticed in a case reported by Glass<sup>2</sup> and cited by Rayer.<sup>3</sup> A girl was born with right hydronephrosis and died at age of 23. At autopsy three gallons of liquid was found in the sac. On interior surface of sac the orifice of the ureter was seen as large as a goose quill. The ureter passed obliquely for twelve inches between the membranes of the sac, and was patent the entire distance to the bladder. On account of the non-obstruction of ureter, Rayer considers this the most remarkable case on record.

Rayer observed a case of double hydronephrosis in which the ureters were also patent, which he attributes to congenital malformation. The patient was a boy of 17, who had been sickly all his life, and had had pain for seven years in the region of the left kidney. A tumor was found and the diagnosis made of left hydronephrosis. He died from septic infection of the sacs. At autopsy, left ureter was found patent, the upper portion situated in wall of sac with an opening almost similar to a valve in a vein. Water passed easily from below upward, but not down from the sac into the ureter. There was a smaller hydronephrosis in the right kidney. The right ureter was dilated to the size of a lead pencil from the bladder up to the sac. At the upper end it was retracted and when water was injected from below, it entered the sac through an opening the size of the lachrymal punctum.

Virchow<sup>4</sup> in discussing hydronephrosis remarks: "The cases are extraordinary in which hydronephrosis exists with the ureter patent. I have examined such cases several times, and have found in each case a valvular obstruction caused by folding of the wall, due to oblique origin of the ureter from the renal pelvis."