

acts lie on the left side of the brain, left-handedness be taught and established in such individuals as showed symbol amblyopia.

I believe that stammering is simply the result of imperfect coordination, caused by disconnected and erratic discharges from the cortex; that the lesion is organic; that it is congenital; and that those persons who have been apparently cured are not really cured, as a matter of fact. It is well known that however much improvement has taken place in a given case, it has always been the result of long-continued treatment, and that the basis of that treatment is repetition of effort on the part of the subject to control the defect in the manner which he himself has adopted or others have suggested. It is also well known that however much better these individuals may have become, they relapse again into their original condition, temporarily, at least, when under great excitement or psychic shock.

I am convinced that stammering should be classed under the congenital defects of the speech centers, and that it is allied to symbol amblyopia.

I suggest, therefore, that in such persons it is reasonable to attempt to transfer the speech center to the opposite side of the brain.

Now it is in the highest degree unlikely that a congenital defect should occur on both sides of the brain and in the same place, so that if children who stutter could be rendered left-handed as soon as the defect is discovered, it might be remedied in early life. Experience should prove the value of the suggestion. As a matter of interest, I may cite the case of my own little boy of 6 years. He was originally inclined to be left-handed, and as soon as this inclination was noted his mother—who is practically ambidextrous—commenced to correct it. Very soon afterward we observed that he began to stammer badly, and he continued to have periods of stammering for two years. He can still use his left hand easily, and appears to prefer to use it at times, but in general he is now right-handed. Since he has acquired right-handedness his stammering has ceased.

This suggestion is made in the hope that others will put the treatment into practice. As stated, it should be started in extreme youth, as soon as stammering is observed, but, of course, there could be no objection to trying it also later in life.

Incidentally there has never been a postmortem corroboration of the assumed congenital lesion in symbol amblyopia.

J. H. CLAIBORNE, M.D.

The Pittsburgh Housing Situation.

PITTSBURG, PA., April 1, 1908.

To the Editor:—I beg to acknowledge with appreciation your editorial in a recent issue¹ on the Pittsburgh housing situation. You rightly indicate that there are three prime factors in evil housing conditions—the landlord, the tenant and the health inspector. I feel, however, that your editorial does not do justice to Dr. James F. Edwards, superintendent of the local bureau of health. This bureau is not an independent department of the Pittsburgh city government. It falls under the department of public safety. Two-thirds of its appropriations are engrossed by a contract system of garbage removal, over which the superintendent has no control. Since 1899 there has been no published report of the bureau of health. Previous superintendents of the bureau have not been physicians. I state these things to you to indicate the large work of reorganization which Dr. Edwards has had to undertake. In facing the conditions he has shown rare spirit and no mean measure of accomplishment, even with an inadequate staff. The housing movement is a case in point. He has removed hundreds of privy vaults in the city proper. He placed every facility of his department at our disposal in getting together the report on housing for the Pittsburgh Survey, to which you referred.

Our findings were used in support of an ordinance introduced by the chamber of commerce, which was in line with Dr.

Edwards' recommendations, and which has just passed. This ordinance will double the force of tenement-house inspectors and for the first time will give the superintendent of health an effective staff for this branch of his work. Reform in this direction has been energetically advocated by Dr. Edwards before councilmanic committees, at public meetings, in the press, and in cooperation with special committees of the Civic Club, Chamber of Commerce, Kingsley House and other local agencies, and in enlisting the services of such outside experts as Lawrence Veiller, secretary of the famous Housing Commission of 1900 of Greater New York.

The local health inspector is in truth becoming an important factor in the Pittsburgh housing situation—a factor for good.

PAUL U. KELLOGG, Director, Pittsburgh Survey.

An Arraignment of Surgery?

NEW YORK, April 1, 1908.

To the Editor:—In THE JOURNAL, March 28, page 1025, last paragraph, Dr. Bayard Holmes, professor of surgery in the University of Illinois, describes the hospital requirements of modern surgery. He says:

All that the surgeon cares for is a room for his patient to occupy during the three or four weeks she is recovering from his incisions. She may then go home and get well or lead a life of invalidism, as it happens. To cure his patient and restore her to a life of usefulness and happiness is not the modern surgeon's conception of duty. He looks on the invalid as an incumbrance to his hospital, and all the essentials of recovery as unnecessary expense and space-consuming impedimenta.

If the professor is not humorously tempting some of us to "bite" in the hope that his paper—otherwise an excellent one—may be more widely noted, then I am indeed sorry for him. I have never met a "modern surgeon" who did not look on it as his highest privilege as well as his duty to do everything in his power to restore his patients, male as well as female, to that state of happiness which the sick always regard as the possession of the healthy. The conscience of the surgeon must be truly callous, if a so-called "operative" recovery satisfies him. To put it very mildly, Dr. Holmes must have come in contact with some very unusual characters in the noble profession of medicine or even of "modern aggressive surgery," to generalize in such a shocking manner.

Let us be glad for the professor's peace of mind that he is evidently sufficiently pharisaical to be grateful that he is not as other surgeons are. But, probably all this preachment is for naught and Dr. Holmes has after all "gotten a rise" out of me.

HOWARD LILIENTHAL.

Hysteria in Italians.

DETROIT, MICH., April 2, 1908.

To the Editor:—I was very much interested in Dr. Baff's article, "Hysteria in Italians." There are a few Italians four blocks from my residence and I can bear out the doctor's statement that the Latin races are prone to hysteria. They seem to me to be lacking in "sand." A hypodermatic injection of apomorphin will (in all cases) quickly put to flight any case of hysteria, let it be an Italian, a vexed prostitute or high-strung woman. About ten years ago a woman was picked up on the street unconscious (sic), taken to the hospital, and her most remarkable, unprecedented case of twenty-four hours' "unconsciousness" commented on by the lay press. It happened a few times; on the last occasion I was called to see her, and one hypodermic of apomorphin completely cured the "unconsciousness." By the way, apomorphin hypodermatically will often abort an asthmatic attack. But for hysteria a "jab of apomorphin" is the sheet anchor.

E. T. MILLIGAN.

Sign of Typhoid.—Giovanni confirms the diagnostic importance of the yellow tint of the lines and folds in the palms and sole of the feet in beginning typhoid fever. He found it one of the earliest signs, and the more pronounced, the severer the typhoid infection proved. In extremely severe cases the yellow discoloration extended up over the sides and back of the fingers and toes. His communication was published in the *Riforma medica*, January 15.

1. THE JOURNAL A. M. A., March 28, 1908, p. 1040.