

written before dinner—and, in any case, I, like “M.D.,” am practically a teetotaler.

I am, Sir, yours, &c.,

Wimpole-street, Sept. 21st, 1908.

CHAS. MERCIER.

ON CHRONIC MORPHINISM AND ITS TREATMENT.

To the Editor of THE LANCET.

SIR,—The article which appeared in your issue of Sept. 12th on Chronic Morphinism by Professor Gamgee is highly instructive and is certainly the best contribution on that subject which I have read. Several theories have been propounded as to the cause of the distressing phenomena which follow abstinence from morphine in cases of chronic morphinism, but in my opinion Professor Gamgee's is by far the most sound. In regard to these symptoms and their treatment there are a few remarks I would like to make. During the last seven years I have treated for chronic morphinism 52 cases and therefore have some little knowledge of the subject. In regard to the symptoms that affect the nervous system I agree with Professor Gamgee, but in regard to the circulatory, respiratory, and gastro-intestinal my experience compels me to differ slightly. The intense cardiac dyspnoea which he speaks of I have not met with, except in one case where the patient had been taking 80 grains of morphine per day before coming to me, and it took six months before the drug was entirely stopped. In regard to the gastro-intestinal symptoms, nausea, vomiting, and gastro-intestinal catarrh, these I have not found common, and when they have arisen I have found no difficulty in treating them, except when the patient has been in the habit of taking the morphine by the mouth. Constipation is as a rule present while the patient is taking the drug, and this may persist for some time after the drug has been cut off; strong purgatives may have to be used whilst the patient is taking morphine, but it is unwise to give these when the morphine is stopped. Enemata and mild laxatives are safer methods, bismuth subnitrate may also be given; with careful management I have always found these symptoms disappear.

In regard to treatment Professor Gamgee designates the sudden withdrawal of the drug as the English method. I do not admit that this is the English method; it may be the method adopted by English asylums, but certainly not by the different sanatoriums or retreats which make the treatment of morphinism, narcomania, or inebriety their special branch of medicine. I myself have invariably treated chronic morphinism by the slow reduction method. Professor Gamgee gives the time of from six to ten weeks in effecting this. This as a rule is too short, the average time being 13 to 16 weeks, and I have had cases which have taken over 20 weeks before the drug was abolished so as to avoid severe suffering and mental distress. I am quite aware that there is such a thing as syringe mania, but I find it far more satisfactory to continue the use of the hypodermic syringe till the last dose is given and even afterwards, when only a saline solution is injected. Giving it by the mouth and leaving off the syringe I have found adds to my difficulties. In regard to the nervous system symptoms—(a) *Insomnia*. After the drug has been cut off there is no doubt insomnia is one of the commonest symptoms complained of by the patient. I agree with Professor Gamgee in finding veronal extremely useful but seven grains is of little use; double that dose is required as a rule to combat this symptom and this drug must be slowly reduced or else insomnia is apt to return. (b) *Uncontrollable restlessness*. This is by far the most common symptom and I think the most trying to the patient, the constant twitching of the legs or arms, or as Professor Gamgee more aptly calls it the “fidgets” in the extremities are very trying and distressing to the patient. I have used for the treatment of this with marked success a preparation containing acetanilide two grains, caffeine citras five grains, sod. bicarbonate three grains. This remedy has succeeded when everything else has failed. (c) *Maniacal and suicidal symptoms* are rare but delirium and delusions are common; these as a rule pass off with ordinary treatment.

Professor Gamgee does not lay sufficient stress on the danger of administering alcohol either when the quantity of the drug taken by the patient is being reduced or has been cut off. In my experience I find that alcohol aggravates all these symptoms, and I would like to add

that after the patient has recovered alcohol as a beverage ought to be avoided. In nearly every case in which relapse has occurred, after having been successfully treated, I find that the use of alcohol started the craving for morphine.

I quite agree with Professor Gamgee in strongly condemning any attempt to cut off the patient suffering from chronic morphinism from the drug at once. It is almost criminal treatment, and I also agree with him that these patients should only be dealt with in a place where treatment can be thoroughly carried out—that is to say, where the hygiene is good, the air bracing, a proper nursing staff kept, and the patient is under the supervision of a medical man who has made a special study and has practical experience of this subject. Professor Gamgee does not refer to the after-treatment to prevent relapse. If patients, after their chronic morphinism is cured, would remain under supervision for a considerable time, say six to 12 months, there would be fewer relapses. A long period would not only give them time to build up their physical strength and establish their general health but would also give them more brain power in resisting temptation to resume their habit.

I am, Sir, yours faithfully,

JOHN Q. DONALD, L.R.C.P., L.R.C.S. Edin.,

Colinsburgh, Fife, N.B., Sept. 17th, 1908.

TO MEDICAL FREEMASONS.

To the Editor of THE LANCET.

SIR,—May I once again, through the medium of your widely read columns, appeal to medical men, and medical Freemasons in particular, for votes for the Masonic schools? At the forthcoming elections in October there is only one medical candidate for the Royal Masonic Institution for Boys, William Henry Collins, son of William C. G. Collins, formerly physician and surgeon, Bath. As there is no medical candidate for the Royal Masonic Institution for Girls votes for that institution can be exchanged and are equally valuable. Votes for either institution will be gratefully received and acknowledged by me.

I am, Sir, yours faithfully,

WILLIAM WILSON,

Secretary, St. Luke's Medical Lodge of Instruction.
184, Goldhawk-road, W.

RHUS TOXICODENDRON AND ARNICA.

To the Editor of THE LANCET.

SIR,—Your annotation on the subject of rhus toxicodendron in THE LANCET of Sept. 19th, p. 887, interested me, because during the last 12 months I have had under my care two cases of dermatitis which were caused by the climbing variety of this plant. Application of a lotion, containing acetate of lead and tincture of opium, gave so little relief that I resorted to a solution of picric acid (picric acid, grs. 4; sp. vini meth., min. 60; aq. destill., ad 1 oz.).

Some years ago I was called to see a woman who was suffering from a most severe form of dermatitis. She had sprained her wrist and her hostess, a keen amateur homoeopath, had applied bandages soaked in arnica lotion, with the result that the patient's hands, wrists, and forearms were inflamed and covered with blisters. Not knowing an antidote for the local effects of arnica we decided to treat the case as a severe scald and used picric solution with very good result. The skin lesions produced by rhus toxicodendron and arnica resemble one another very closely, and the remedy which had acted well for arnica proved equally efficacious for rhus toxicodendron. The solution was applied in the form of compresses, where these could be easily kept in position by a light bandage, and to the parts where this was inconvenient the lotion was applied frequently with a very soft camel-hair brush. It quickly relieved the pain and hastened the healing of the blistered surfaces. The only drawback is its vivid yellow stain which takes a few days to fade away. Some chemists are unwilling to keep picric acid in stock because of its dangerous explosive properties; the solution, however, is perfectly harmless.

As for the therapeutic uses of rhus toxicodendron I have found it of some value in the treatment of that troublesome symptom, nocturnal incontinence of urine. I have given the tincture in five-minim doses, combined with nux vomica and buchu, to a number of young school boys who were suffering from this weakness. It has certainly failed in a few very

obstinate cases but, although continued over several months, I have never observed any toxic effects.

I am, Sir, yours faithfully,
Mansfield-street, W., Sept. 21st, 1908. H. LYON SMITH.

SPASTIC CONSTIPATION.

To the Editor of THE LANCET.

SIR,—In the annotation on Spastic Constipation, published in your last number, it is stated with truth that the condition has “not received the attention in this country which its frequency warrants.” But Dr. Gustav Singer falls into a common error when he ascribes its recognition to Cherchevsky in 1883, as an excellent account of the condition was written half a century earlier by an Englishman. In 1830 John Howship, surgeon to St. George’s Infirmary, London, published a small book of “Practical Remarks on the Discrimination and Successful Treatment of Spasmodic Stricture in the Colon, considered as an occasional cause of habitual confinement of the bowels.” He describes how in some cases of constipation “the complaint does not so much consist in a defective power of contraction in the whole extent, as in a deficient freedom of relaxation in some one part of the intestinal canal.” It should also be remembered that enterospasm, an important article on which was published by Dr. H. P. Hawkins in the *British Medical Journal* in January, 1906, is another name for the same condition, and that many people in England who are unfamiliar with the term “spastic constipation” are well aware of the comparative frequency of “enterospasm.”

I am, Sir, yours faithfully,
London, Sept. 23rd, 1908. ARTHUR F. HERTZ.

SOME DISCURSIVE REMARKS ON THE REARING OF CHILDREN IN LONDON.

(BY A SPECIAL CORRESPONDENT.)

I.

THE CARE OF INFANTS IN TOWNS.—CONTINENTAL SCHEMES.
—THE CHELSEA KITCHENS.—THE ST. PANCRAS SCHOOL FOR MOTHERS.

THE schemes set on foot by public bodies and by private philanthropic workers to combat the sickness and especially the high rate of mortality which prevail among city-born children are now very numerous. It is much to the credit of the public opinion that it should be so, and it is good to know that all such schemes have had their starting point in the scientific, clinical, and statistical information supplied by medical men. The decreasing birth-rate of this country, coupled with an infantile mortality which, though good compared with that of the United States and many continental States, is still unduly high, has aroused those willing to do something more than to talk about race decadence to make some organised attempts to improve matters. Of all modes to check infant sickness and mortality the improvement of the milk-supply is, of course, the most obvious. Everyone has been able to see that the purer the milk-supply the better in every respect would be the health of mothers and children, whether we are talking of infants who are unfortunately not able to be breast-fed or of babies who have reached the normal age for an independent food-supply. Attention has therefore for a long time, though in no systematic way, been paid to the milk-supply of the young, and this with full knowledge that questions of housing and questions of parental ignorance were at least as important. For a clean milk-supply is a good deal wasted on a parent who does not know what to do with it and has nowhere to keep it. The workers in the cause of infant health have most of them felt that the housing of the poor was the biggest thing of all, but they saw also that if they withheld their efforts until this immense matter was dealt with there would be endless delay. But they saw that they could do much to combat the poverty and ignorance of many mothers of the lower class by systematic instruction in the treatment of their offspring, so as to help them to nourish their infants properly by suckling and to demonstrate to them that breast-feeding is the natural and most healthy manner in which to rear an infant. The object of writing these articles, which I have called

“Discursive Remarks”—for they are no more—is to give the results of some personal observations of certain of the plans which have been adopted in London during the past few years to afford the children of the poor a fair opportunity of becoming physically useful citizens.

I will first describe the schemes now in working order in London to promote breast-feeding among poor mothers. The point here is what has been *done*—not what has been *written*. It is of no use at all to write in medical journals, and not much use to write in lay journals, advocating breast-feeding. A certain amount of public attention is aroused and some workers may thus be stimulated to action, but the poor are not themselves directly influenced by anything that is written on the subject. The very poor, speaking generally, do not read at all, or if they do they take no heed to advice on such matters from a printed page. The sole means of reaching their intelligence is to get into personal relations with them, so as to urge them by word of mouth to give their offspring fair play, while assisting them in a material manner to suckle their children and otherwise to bring them up in accordance with the main laws of health. But this is not always easy, as many enthusiastic workers have found. There have been narrow and intolerant persons among the visitors of the poor and to win the confidence of those who have suffered from the Jellybys is by no means an easy task. Moreover, it is natural for self-respecting citizens to be jealous of outside interference with their domestic affairs and to resent the invasion of their homes by strangers, while it must be remembered that all mothers who are injudicious or ignorant are not necessarily wastrels. Negotiations to assist the mothers must be conducted with discretion and tact lest natural susceptibilities should be wounded; and when confidence is gained, as a rule, parents, especially young parents, will listen to, and will follow, advice beneficial to the health of their children and themselves. It is easier perhaps to interest the parent in her own health than in that of the children who seem to her to be thriving at least as well as children in her circles generally do. But pregnant mothers are quick to learn, or are already aware, that if they are not adequately nourished the child will be born in unfavourable circumstances and that they may not be able to supply it with fitting nutriment. The first step in the direction of promoting breast-feeding is to see that the expectant and nursing mothers are themselves well fed, and with this end in view several philanthropic schemes are now running in London with a certain measure of success. The feeding of nursing mothers seems to have been first given a trial in Chelsea among London districts, and this was one of the earliest attempts in Great Britain to deal with the matter, although on the continent for several years there have been organised attempts of the sort. The benevolent institution of “Allaitement Maternel” founded by Madame Bequet de Vienne in 1876 for the care of the enceinte poor developed in 1892 into a home in which such women were fed, clothed, and treated. A little later Madame Coulet launched in Paris, by means of the association known as “Œuvre du Lait Maternel,” a free restaurant for nursing mothers. Both these institutions have been noticed before in the columns of THE LANCET. The latter undertaking was at first conducted on a very modest scale, the original restaurant being established in the abandoned shop of a dealer in cast-off clothes. At the present time the association has five free restaurants situated in the poorest parts of Paris and these supply many thousands of free meals to poor nursing mothers. No questions are asked of the applicants for the meals. They may be married or single, but if they are nursing mothers and hungry they are made welcome. A free restaurant on similar lines was established in Nice in 1906 and the Social Union of Dundee opened the first restaurant for nursing mothers in that city in May, 1906.

Mrs. W. E. Gordon, a lady living in Chelsea, inspired by the success of the work done in aid of nursing mothers by Madame Coulet, determined to pursue a similar course in Chelsea. Notice of the project was sent to the district visitors, the medical men and the clergy of the neighbourhood, and to the sanitary inspectors of the borough, as also to the ladies who visit the maternity cases in charge of the obstetrical department of St. George’s Hospital. In January, 1906, a room was hired and opened in Arthur-street, Chelsea, at which good meals could be obtained by nursing mothers on payment of 1d. The scheme flourished