

it or not. Here there is room for reform, but I am not prepared with a definite scheme. We have recognised it, and our superintendent has tried to grapple with it in one or two ways. Extra bread is given to those who can eat it between meals from what is left, but it is made more appetising by a little jam or marmalade. Meat left over is made into little hashes, whilst spare potatoes are always used in some little dish. You know from your experience of your union hospitals that the sick cannot eat each day the diet on their bed-cards, but you must have a diet scale, and this must be drawn daily, otherwise the patient will complain. This is one part of Poor-law economics upon which collective wisdom may throw a light.

The dietetic question presents another aspect in reference to the use of stimulants. My rule is the same that I employ with my private patients. I order stimulants, but not in a routine way. Beer is rarely given, never *pro formâ*. Other stimulants are given in medicinal doses, in ounces—so many tablespoonfuls so many times a day. I have fully considered this question in all its bearings. I admit that there are many who are brought to the union hospital through drink and improvidence therefrom, but they do not amount to 18 per cent. My statistics on this point agree with those of one of the greatest observers of the habits of the very poor—viz., Mr. Charles Booth—who, inquiring into the condition of 4000 of the submerged, found that of those reduced to poverty 4 per cent. were loafers, 14 per cent. were addicted to drink, 27 per cent. were poor through illness or had been the victims of misfortune, and 55 per cent. were thrown out of employment. So that this reason cannot be legitimately urged—viz., that for the benefit of the 18 per cent. we should penalise the 82 per cent. whose illness may be due to legitimate causes. I admit that the medical officer should exercise vigilance over the use of stimulants, but his hands should not be absolutely tied.

Before passing from the environment of the hospital, where nowadays the sick poor are humanely treated, where dietaries and nursing are ample and where medical aid is of the most effective kind, I might add one or two words on the humanising influence of the nurses, on the healthy influence they exercise on their patients—influences which have to my knowledge extended in many cases outside the hospital walls, leading to a return to better ways on the part of many men and women. We cannot measure in money weight human sympathy or the kindness or devotion to work on the part of the nurses, but yet I venture to say it has to be reckoned with as a great economic force. I also cannot but think that the personal visits of the guardian who disinterestedly and kindly interests himself in hospital work, visiting the wards, encouraging all by his words, lifting the fallen, reproving maybe, but sympathising with deserving objects of charity, must also have a high economic value.

The sick poor who are admitted to the modern union hospital are more fortunate than those who remain outside in their own homes, and my final words will be briefly devoted to outdoor medical relief. The same principles are applicable. Effectual aid is equally desirable. Is it available? You have a large staff of medical officers who are engaged to attend the outdoor poor at their own homes, to give not only first aid, but to attend in prolonged and serious cases of illness. If we look at the economical conditions of this staff we shall find that the principle of economy is very manifest. Medical officers are appointed who have large, sometimes enormous, districts, who find their own medicines and appliances, and who are paid at such a scale that each visit is remunerated at a very low rate.

The old argument is used. The law of supply and demand comes in. If guardians can obtain medical men at such a price, why should they pay more? The answer is not for me to give; but I am anxious to direct your attention to some aspects of these appointments. Efficient aid is what is wanted. Neglect may convert a common cold into a serious illness. The medical officer who is called in ought, in order to complete his work, to be able to prescribe for his patient and also to order any necessary food. It appears to me that it must hamper the medical officer to find all necessities out of his salary, and certainly as he deals with disease in the most unfavourable surroundings he requires other help. His medicine alone can do very little good unless supplemented by nursing in the houses of the poor. The outdoor Poor-law nurse seems to me a fitting complement to perfect the system. This nurse should visit all cases attended by the Poor-law medical officer, and give force to all the medical directions. She should supervise all removals to hospital,

and she should assist in many other ways. I am not in favour of increasing the work of the outdoor medical officer by this—viz., by keeping cases out of the hospital under his care. No, I think that it is better to send into the hospitals all cases that require prolonged or careful nursing and good food. I very much regret to note that there is such repugnance to the workhouse hospitals, that patients remain out as long as they can, often without medical aid, and sometimes only enter to die, swelling the death-rate in our hospitals. The guardians also know that a number of patients are sent in who are approaching their end. It is difficult to know how to deal with this class of cases. In many instances it would be more economical to increase the outdoor relief for the few days such patients may live, besides being more humane. With outdoor nurses this would be possible. We cannot disguise from ourselves that there is, too, a repugnance to apply to the parochial medical officer. This feeling is laudable, but is a reflection on the system which ought not to exist at the present day when guardians are humanising their work. I do not want you to break down the barriers or to make it any easier to obtain free medical advice. No, but I do want to convince you that you ought not to give simply cheap medical advice; that as you are entrusted by the State with the relief of suffering amongst the poor, you should give effectual medical aid, and that you cannot give effective aid without the best machinery.

Gentlemen, in conclusion I can only repeat that I am not a *doctrinaire*. I give you my views and suggestions for what they are worth. It needs great care in administering your Poor-law funds, avoiding parsimony as well as extravagance. There never was a time when the needs of the deserving poor were more carefully considered and relieved, and there is no country like England where the sick poor are so tenderly and devotedly nursed. Medical advice in sickness is the great question of the day agitating the philanthropists from one end of England to the other. All kinds of schemes have been formulated to grapple with sickness amongst the labouring poor; but I hold that with an efficiently organised Poor-law system no poor person should dread the approach of sickness, and that for medical aid in sickness there should be no stigma in accepting such aid from the Poor-law.

Halifax

PUERPERAL SEPTICÆMIA TREATED WITHOUT STREPTOCOCCIC SERUM; RECOVERY.

By EUSTACE M. SWANWICK, L.R.C.P. LOND.,
M.R.C.S. ENG.,

PHYSICIAN TO HARTLEPOOLS HOSPITAL.

THE above title is used to compare the case with the very full and interesting account of a case of puerperal septicæmia given by Dr. Rawlings in THE LANCET of Aug. 7th last. As in Dr. Rawlings's case, so in mine, there is no account to offer in the way of bacteriological examination.

A primipara, aged twenty-three years, whom I was engaged to attend at the end of July, sent for me on the morning of July 14th, 1897. The labour began about 1 A.M. The head presenting in the third cranial position made the labour slightly less normal than otherwise it might have been. A small quantity of a mixture of chloroform and rectified spirit relieved the urgency of the pain and the child was born at 5.25 A.M. There was a slight perineal tear, hardly to be dignified by the name of rupture, as it did not seem to involve any muscle. Before each infrequent examination my hands were rinsed in a 1 in 1000 solution of perchloride of mercury and lubricated with carbollised vaseline. On completion of the third stage a soluble pessary containing ten grains of iodoform was passed high up into the vagina, a binder applied, and the patient was left feeling comfortable. About 10 A.M. the temperature was 99° F. and the pulse was 84; there was no pain or malaise. In the evening the urine was drawn off with a catheter, well washed in disinfectant. During the 15th the patient seemed to be going on well. On the 16th, at 12.30 P.M., the temperature was 100° 8'; at 2.30 P.M. there were pains all over the head, back, and limbs, and a feeling of cold water down the back, but no full rigor; the

pulse was 124 and the temperature was 104.6°. I gave a powder of fourteen grains of phenacetin and ordered seven grains to be given every four hours, a mixture containing acetate of potash and tincture of aconite, and an iodoform pessary to be introduced. There was no marked abdominal tenderness, but some tenderness of the fundus was present. Vaginal examination showed a slightly retroflected uterus with puffy cervix. There was no difficulty in reducing the flexion. No malodour was apparent in the scanty discharge. I called on the district professional nurse and asked her to administer night and morning an injection of hot solution of Condy's fluid and an enema of one pint of plain water, also hot. I diagnosed the case as puerperal influenza.¹ The tongue was of the influenza variety, moist and slightly furred. On July 16th, at 12.30 P.M., the temperature was 100.8°, at 2.30 P.M. it was 104.6°, and in the evening it was 103°. Subsequently the temperature was as follows:—

Date.	Morning.	Evening.	Date.	Morning.	Evening.
July 17th ...	101.0°	98.6°	July 22nd ...	99.8°	100.2°
" 18th ...	100.0°	99.0°	" 23rd ...	99.8°	98.8°
" 19th ...	101.4°	103.4°	" 24th ...	98.4°	99.0°
" 20th ...	100.2°	102.2°	" 25th ...	98.4°	—
" 21st ...	100.2°	101.4°	" 26th ...	98.6°*	—

* Became subnormal.

On the 17th and 18th she had nocturnal delirium and I prescribed 30 grains of bromide of potassium and one drachm of ammoniated tincture of valerian in two ounces of water; this was to be repeated night and morning when the restlessness was extreme. On the 19th she had diurnal as well as nocturnal delirium. On the 21st I gave her a sulphate of quinine and hydrobromic acid mixture. From the 16th to the 21st the pulse varied from 110 at first to 140; it was generally about 132. On the 22nd I reduced my visits to one each day and the nurse took the evening temperature. On the night of Aug. 26th–27th the patient had chills and pains all over. The temperature was 100.8°. No puerperal condition could be made out. I ordered the mixture of acetate of potash and aconite together with the phenacetin powders. On the 27th, at 10 A.M., the pulse was 108 and the temperature was 99.6°; at 10 P.M. the temperature was 102°. On the 28th, at 10 A.M., the pulse was 108 and the temperature was 99.4°; at 9 P.M. the temperature was 98.4°. On the 29th, at 11 A.M., the pulse was 72 and the temperature was 98°.

Remarks.—Owing to the preliminary diagnosis of influenza I was led to make inquiries about previous illness. The hypothesis is that if there is no influenza at the time of labour or delivery the puerperal trouble begins at the end of the fifth day; if the patient has influenza at the time of labour there is a respite for two and a half days, and the influenza then reappears, generally in a different form, and frequently in a puerperal form.² I found that the patient had had chills and pains all over on July 9th, and she had noticed that her feet were swollen on the 7th. The labour was before the expected time, a common occurrence in influenza, and began about 1 A.M. on the 14th. The temperature chart shows on the 16th the rise beginning about 12.30 noon and a high temperature by 2.30 P.M. Except for absence of streptococcic serum treatment I treated the case on general puerperal fever principles, keeping the parts disinfected by Condy's washes and iodoform, while I treated the fever as an influenzal condition, avoiding stimulants and narcotics at first. When the patient was nearly out of danger, and her sister was congratulating herself and me on her recovery, I told her they must look out for a recurrence of the attack in seventeen, thirty-five, or fifty-one days from the commencement,³ but that if they let me know at once on its recurrence we should probably be able to cut it short in three days. The tongue at that period was of a distinctly influenzal character. Now seventeen days from the 7th, when she noticed her feet swell, brings us to July 24th, when the patient was weak but convalescent in bed; thirty-five days, to Aug. 11th, on which date no new symptoms occurred; and fifty-one days to Aug. 27th. On the night of the 26th the temperature rose to 100.8° and the case ran as described above. As these cases occur so frequently in a more or less distinct form one is disposed to look upon them as a puerperal catarrh of an influenzal nature. The deaths from them are rare if treated as a catarrh. Out of a very considerable number of such cases I can remember only once losing a patient, and I believe that was a case of true "puerperal" fever engrafted on the influenzal catarrh, due to want of

cleanliness on the very unprofessional nurse's part and general inattention to directions, the patient from the beginning having to attend to most of her wants as best she could. I cannot call to mind any similar cases anterior to the influenza of 1889, when they became frequent. The milk-supply also is generally unaffected, and if there is any malodour about the discharge it is of a peculiar mousey nature, which I cannot call to mind as occurring in any other complaint. I saw my patient on Sept. 11th and sent her into the country. She nursed the flourishing infant until the middle of October. At this time the child was taken from the breast owing to the nervous condition of the mother, who is to-day (Nov. 16th, 1897) doing well.

There are so many points in common between Dr. Rawlings's case and the above, and the injections of anti-streptococcic serum were in his case, so ineffectual, that it is suggested that we have a catarrhal germ infection not of a streptococcic nature. If the relation of these cases make us all more careful in future to look for the streptococcus it will be the means of our learning to distinguish between the various forms of puerperal fever.⁴

West Hartlepool.

A CASE OF ABSCESS OF THE LIVER; RUPTURE INTO THE LUNG; RECOVERY.

BY T. GLOVER LYON, M.D. CANTAB., M.R.C.P. LOND.
PHYSICIAN TO THE CITY OF LONDON HOSPITAL FOR DISEASES OF
THE CHEST.

FOR the notes of the following case I am indebted to Mr. Charles Lamplough, resident medical officer.

A man, aged thirty-five years, costermonger, was admitted to the City of London Hospital for Diseases of the Chest on Aug. 5th, 1897, complaining of diarrhoea and pain in the right side. He had never been out of England. His bowels had acted two or three times daily for two years, but with little or no abdominal pain or tenesmus, nor had he noticed any blood in the evacuations. He had had a slight cough for twelve months, and during the three months prior to admission he suffered from "shooting" pains down the front of the right chest with shortness of breath on exertion. On examination the patient was found to be a well-developed man, though emaciated and anæmic. No jaundice was noted. He had a slight cough with scanty mucoid expectoration and complained of a sharp pain over the right lower ribs in front. The chest was of good shape and expanded fairly well and equally. Anteriorly there was comparative dullness from the lower border of the fourth right rib in the nipple line to two inches below the costal margin; behind, the percussion note was comparatively dull below the inferior angle of the right scapula. Over the dull area the breath sounds, vocal resonance, and fremitus were much diminished, though not entirely lost, but no moist sounds were audible, nor was the voice of ægophonic quality. The heart's apex beat was in the fourth left interspace half an inch "inside" the nipple line. The sounds were free from murmur, the pulmonic second sound being accentuated. The pulse was 92, regular, and of fair tension and volume. The abdomen was slightly distended and tympanitic, not tender, but very resistant. The lower edge of the liver could be indistinctly felt about two inches below the costal margin. The spleen was not palpable. The bowels acted two or three times daily, the stools being large, fluid, and very pale, containing no blood or mucus. The temperature varied from 99° to 101° F. daily. The diarrhoea, pain over the upper part of the hepatic area, the enlarged liver with great abdominal resistance, the diminution of breath sounds, and the slight elevation of the heart without lateral displacement towards the right, together with the remittent temperature, suggested the diagnosis of abscess of the liver. Three exploratory punctures were made into the lower part of the right chest over the painful area, but nothing excepting a little blood was withdrawn. The patient gradually became worse until Aug. 16th, when suddenly at about 3 A.M. he had a fit of coughing, lasting on and off for about two hours, during which he expectorated about six ounces of dark fluid,

¹ Vide Dr. Gray's Influenza (H. K. Lewis), pp. 37 to 44.

² Op. cit.

³ Op. cit.

⁴ Compare also Dr. Groth's case in THE LANCET, Aug. 14th, 1897.