

of indol-producing Pfeiffer bacilli. Fifty-eight different normal persons have been examined with this in view. A positive indol reaction has been obtained in forty-eight, a negative in ten, making the proportion of positive indol findings from throat swabs about 83 per cent. Seven of the persons giving positive indol reactions from throat swabs had a history of influenza in the fall of 1918; also three of those giving negative reactions.

Seven of those giving negative indol reactions were retested (from a few days to a few weeks later) and four of these yielded indol on the second testing. In three of these both tonsil and nasopharynx swabs gave indol; in the other only the tonsil swab.

If a peptone phosphate medium is used in which *B. coli* and other indol-producing bacteria give abundant indol, no indol is formed after inoculating with throat swabs although good growth occurs. Parallel tests with swabs taken from the same throat at the same time have shown indol production in the blood broth but never in the peptone phosphate medium. Apparently, therefore, a hemophilic organism is the one responsible for the indol production from throat swabs.

It seems a fair presumption from the available data that indol production in blood broth inoculated with throat swabs is due to the presence of indol-producing strains of the Pfeiffer bacillus, although a final judgment on this point is hardly possible at the present time. Should this presumption prove to be justified, these results indicate the presence of Pfeiffer bacilli of this type in approximately 80 per cent. of normal throats. This is a higher proportion than usually obtained by the ordinary cultural methods. In the cases examined in this series the presence of the Pfeiffer bacillus was indicated in about 40 per cent. by the blood agar plate cultural method, as compared with about 80 per cent. by the indol presumptive test.

Clinical Notes, Suggestions, and New Instruments

A METHOD OF DELIVERING THE PLACENTA

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I desire to present a procedure for the expulsion of the placenta. Physicians in general have accepted the dictum that the third stage of labor should be allowed to develop naturally, and that no attempt should be made to express the placenta until separation has occurred, provided there is no hemorrhage.

The interval between the birth of the child and the moment of expression of the placenta is still being handled in different fashion, according to the teachings of various clinics, ranging from the absolutely let alone policy of Leopold, who insists that the abdomen should be left untouched following the birth of the child, if need be for twenty-four hours, leaving the expression of the placenta absolutely to the natural powers of the woman; to the other extreme, which consists in grasping the fundus, and as soon as contractions have appeared or have been called forth by massage, to express the placenta. Omitting a critical consideration of the merits of these various procedures at this time, and limiting myself to a discussion of the act of expulsion, I think the consensus of the best obstetrical opinion of today, in this country at least, is that after a suitable period of

waiting, which averages half an hour, the uterus having undergone sufficient contractions, the placenta being separated and lying in the lower uterine segment, it is then permissible to grasp the fundus directly over its center, and the uterus being in contraction and in midline, to express the placenta.

In skilled hands, with a proper recognition of the risk of too much traumatism resulting in a metritis, and of rupture of a pus tube by grasping the fundus laterally instead of centrally, this procedure is entirely without danger. However, if there is a way in which the natural powers of the woman, both voluntary and involuntary, can be utilized for the purpose of expression without handling the uterus, I am sure this is preferable. All of us have seen the not infrequent cases in which the woman spontaneously expels the placenta directly after delivery, or just as we are about to express it for her. In a great majority of cases her inability to accomplish expulsion spontaneously is due to the complete loss of tone of the abdominal wall just released from its prolonged condition of overstretching. If the abdominal tone and the intra-abdominal pressure can be restored for the time being, the woman has regained her voluntary powers of expulsion.

For some time I have been accomplishing this in a very simple way. After the usual period of waiting, averaging half an hour, and when the uterus is at the height of a contraction, as evidenced both by feeling it and by the pain the woman is experiencing, I grasp the abdominal wall crosswise above the fundus and pull the rectus muscles together, thus taking up all the slack. I then encourage the woman to bear down, and in practically every case in which expression on the fundus would have succeeded, this procedure has succeeded. If then there should be adherent membranes, they are treated in exactly the same fashion as following any other method of expression. The advantage claimed for this procedure is a total avoidance of handling or pressure on the uterus, and I believe that any device that will help to achieve that end, and give the same result, is worth advocating.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION.

W. A. PUCKNER, SECRETARY.

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Actions and Uses.—See general article Silver Preparations (New and Nonofficial Remedies, 1919, p. 307).

Dosage.—Protargentum-Squibb is used in 0.25 to 5 per cent. aqueous solutions, which should preferably be prepared fresh as required. Solutions are best made by sprinkling the powder on cold water without stirring.

Manufactured by E. R. Squibb & Sons, New York. No U. S. patent or trademark.

Protargentum-Squibb is obtained by the action of silver nitrate on gelatin in the presence of an alkali, precipitation by alcohol and drying *in vacuo*.

Protargentum-Squibb is a chocolate colored, odorless powder, readily though slowly soluble in water, insoluble in alcohol or oils.

An aqueous solution of protargentum-Squibb is alkaline to litmus, but neutral to phenolphthalein. An aqueous solution is not affected by addition of albumin nor by cocaine hydrochloride in weak solution.

When an aqueous solution is treated with sodium chloride, no precipitate is produced although opalescence occurs; no precipitate is formed on the addition of acetic acid.

Dissolve about 1 gm. of protargentum-Squibb, accurately, weighed in about 10 Cc. of distilled water, add 10 Cc. sulphuric acid, U. S., and sufficient powdered potassium permanganate so that the color of permanganate persists for ten minutes (about 2 Gm.). Decolorize the liquid with powdered oxalic acid, add 10 Cc. nitric acid (25 per cent.), heat on a bath of boiling water for fifteen minutes to destroy excess of oxalic acid, cool, dilute with 50 Cc. distilled water, add 5 Cc. saturated solution of ferric ammonium sulphate and then titrate with tenth-normal volumetric potassium sulphocyanate solution. It should show not less than 8 per cent., nor more than 9 per cent. of silver.

Each c.c. of tenth-normal volumetric potassium sulphocyanate solution corresponds to 0.010788 Gm. silver.