

to headaches to develop them from taking iron is well known. In cases where Blaud's mass, the chlorid, citrate or dry sulphate of iron cause any increase in the symptoms we usually administer the lactate, which we have found much freer from unpleasant effects in headache patients. We have met with little satisfaction in the use of the many and much vaunted forms of so-called organic iron. Arsenic in the form of arsenate of soda is less irritating to the stomach than Fowler's solution, or if combined with mercury in the form of Donovan's solution is of the greatest value in many obstinate cases, especially of the more severe types. In headaches involving the distribution of the supraorbital, or of any other definite nerve in the scalp, we have found great benefit and often permanent cure from the systematic use, up to the point of toleration of each drug, of two grains of quinin sulphate and 1/400 of a grain of nitrate of aconitin given every two hours in separate tablets, so that either can be discontinued on the appearance of the appropriate indications.

In some cases of migraine, especially where exophoria was present and the pain principally in the temple or occiput, we have found marked benefit from the use of cannabis indica in from 1/8 to 1/4 grain doses of Hering's extract three times a day continued for a long period. In the matter of drug treatment the same attention to details is of importance as in the fitting of glasses. The physician who prescribes such drugs as aconitin, cannabis indica or ergot without the most careful supervision of their quality will constantly be disappointed in the results.

The importance of the toxic element in the immediate bringing on of an attack of migraine is well illustrated by the best methods for aborting the beginning of the attack. Thorough lavage of the stomach, followed by the administration of salicylate of soda or aspirin combined with a good dose of caffeine, or, still better, given in strong black coffee, has proved of more service in our hands than any other treatment when the attack first begins. Another resource when the pain is principally frontal is spraying the nose with a very strong, say 20 per cent. solution, of cocain. The character of the drug should be unknown to the patient. When called to a case in the midst of a violent attack of any kind of headache, which is well under way, we do not hesitate, if we are fairly well satisfied that it is due to an ultimately removable cause, to administer a hypodermic injection of morphin with atropin and to repeat it if necessary until the patient is comfortable. In a severe headache, which has already lasted for a couple of hours, we are convinced that even where there are no particular gastric symptoms the stomach is in such a condition with the majority of patients that any drug put into it is simply wasted as far as relief is concerned, and many of the unpleasant results of using the coal tar products have been due to the administration of repeated doses under these circumstances, where no relief was obtained until the headache began to go off of itself, and then all the successive doses were apparently absorbed about the same time. Where one does decide to make use of the coal tar analgesics, antipyrin has seemed to us much the safest and as efficient as any other. We always guard it with caffeine, and the same effect will be obtained from a much smaller dose if the drug is administered in an effervescent form. The hard compressed tablets, so commonly in use, dissolve with greater difficulty than many realize, and a powder is much preferable where an effervescent salt can not be used.

DISCUSSION.

DR. WM. HEALY, Chicago, has seen cases in which, although no correction of vision was needed, reduction of the amount of eyework brought about cessation of the pain. On the other hand, in cases in which refraction was done by a good man and even corroborated by another, there were frequent recurrences of the headache until there was a decided reduction of the work done by the corrected eye. Eye-strain which causes headache may, he said, be either use of eyes which refract imperfectly or it may mean merely overuse.

DR. HUGH T. PATRICK, Chicago, speaking of the relation of migraine to eye-strain and the relation of eye-strain to migraine said that the author's results in the treatment of migraine by the adjustment of glasses have been very much more fortunate than have his. Every case of migraine that comes to Dr. Patrick is at once sent to a competent oculist, provided an eye examination has not already been made. Ordinarily the eyes have been attended to before he sees the patient. But the cases in which the migraine has been cured by the adjustment of glasses are of the extremest rarity in his experience. This is, of course, assuming that the headache is really migraine. The single element of heredity, Dr. Patrick thought, would throw some light on his poor results, because in the cases he sees the element of heredity, not only indirect but direct heredity, is of surprising frequency. The fact that the patient has what she calls sick headache, that her mother had what she called nervous headache, and her grandmother had what she called neuralgia, does not alter the fact that all three had migraine, and, if that fact is taken into consideration, there will generally be found somewhere in the family a history of migraine. Dr. Patrick inclined to the belief that some of the men who get such very brilliant results from the adjustment of glasses in migraine are not dealing with typical cases. Heredity also plays an important part in the production of the refraction errors, and that parents with errors of refraction are very apt to have children with errors of refraction, but, nevertheless, Dr. Patrick does not believe that cases of migraine are cured by the adjustment of glasses, at least not in the proportion mentioned by the author.

TRICHOPTHOPHOBIA.

FEAR OF DISEASE OF THE HAIR.*

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The subject of the pathophobias is such an extensive one and so particularly within the scope of neuropathology that my object is simply to classify those pertaining to the hair and to speak of some of the diseases of the hair and scalp giving rise to them. Under the term trichopathophobia, from *τριχ* hair, *πάθος* disease, and *φόβος* fear of, I wish to include all those cases of mental worry in regard to the hair, such as: Worry over the loss of hair or over the hair falling out; worry over the color or change in color of the hair; worry over a change in characteristics—brittleness, kinkiness, lack of gloss, etc.; worry over excessive growth in unusual places—hirsutes, hypertrichosis; worry over the failure of hair to grow where it should.

THE FEAR OF THE HAIR FALLING OUT.

The rôle played by the hair as a fetich of sexual attraction is so well known as to be consciously or unconsciously employed by both sexes. In the lower animals it is the male who parades his hirsute adornment as a means of sexual selection, and in savage races it is even

* I wish to thank Dr. Achilles Rose, well known for his writing on medical onomatology, for his interest and assistance in selecting the word "trichopathophobia" to describe these conditions.

to-day the male who most adorns his head dress. Civilized man has relegated this form of vanity to the female sex, although he is not entirely free from hair vanity, especially facial hair vanity.

The greatest number of cases of hair-worry is in women, and this is quite natural under modern conditions which makes them, as Bernard Shaw says, "superman" as regards sexual attraction. Hence the enormous amount of time and thought which women bestow on the arrangement and care of the hair. This is excusable on psychological grounds much more profound than simple vanity. The anxiety of a nervous woman at the loss of her hair is not at all reassured by the indifferent or stereotyped explanation of the physician that each hair has a definite growth, falls and is replaced by a new hair. Such women continue to worry until their anxiety in keeping daily count of the number of hairs lost at each combing may increase until it becomes a veritable obsession.

This worry, of course, is most marked in neuropathic women, but, since urban conditions are so trying to nervous stability, it is very common in society women. Women leading lives of social calls, teas, theaters, card parties, balls, late suppers and that constant *surmenage* which so often results in an enforced sojourn in a sanitarium. The following case may serve as an illustration:

Patient.—Miss X., aged about 39, fond of society, cultured, imaginative and pardonably vain of a heavy head of yellow hair.

History.—She came to me complaining of the serious damage which had been done to her scalp and hair while in a sanitarium for an attack of influenza. She stated that while in the sanitarium she had used some water in a bowl which had been brought from the kitchen and which must have contained some powerful chemical, since immediately after using this water her scalp began to burn. After a few days her hair began to change color, losing its gloss and becoming gray. The scalp became dry and scaly and the hair began to thin out. After some weeks another accident happened to her scalp from using some well-water containing lime and sulphur, as she had ascertained from a chemical analysis which had been made for her by a druggist. As a result of the use of this water her scalp burned as if something were eating into it. This burning lasted for about two months, the hair becoming thinner and grayer. Following this she gave a history of various mishaps resulting from the treatment given her scalp by hair dressers, physicians and dermatologists. In one case the damage was caused by the use of a strong carbolized vaselin, in another case it was due to an ointment of resorcin and sulphur which had been used for a number of weeks only to find her hair becoming thinner and grayer. Finally she gave up the use of all treatment except olive oil and despaired of ever getting well—even feared she would lose all her hair. She was, at the time of consulting me, so suspicious of further damage as to be almost hysterical about allowing anyone to touch her head. Insisted on my hands being disinfected with bichlorid solution before touching her hair. She objected to any form of medication and said that she would allow only distilled water to be used for a shampoo.

Now what was the condition of her scalp at the time of her first visit? As far as objective appearances went it was absolutely normal. Her skin was thin, dry and subject at times to erythema and chapping. It was impossible to make an examination as to paresthetic areas or to find any definite ground for diagnosing hysteria. But it was clearly evident that her loss of hair and the change in its color was more subjective than real and in any case more attributable to the result of the attack of influenza and the resulting neurotic condition than to what she had used. Nothing a physician might order for external use would be free from sus-

picion. The case was one for general hygienic treatment and suggestion. Unless such a patient's confidence can be gained it is useless to order any stimulating lotion, as all sorts of imaginary changes in the scalp and hair will surely be attributed to the local application.

I am indebted to Dr. J. M. Winfield, of Brooklyn, for the history of the following case, which bears many points of resemblance:

Patient.—Mrs. M., aged 35, a native of the U. S., and the mother of two children, 12 and 8 years of age, respectively.

History.—As a young girl and as a married woman she has been very proud of her hair, which was fine, silky and of a golden color and very abundant. Five years ago her hair began to fall out. She had not been ill nor was there any ascertainable cause. At first she paid but little attention to the hair falling, thinking it was natural, but later, however, on its continuing to fall, she became nervous and mentally depressed. I saw her a number of times. She gave the history of a spoiled child and wife; being rather pretty (of the doll type) the loss of hair made her melancholic. While she had lost quantities of hair she still had more than most women. From a condition of neurasthenia she has become almost a fit subject for an institution for the insane. She had lost flesh, did not eat, was suspicious of her husband's fidelity; would not go out during the day because "people made remarks" about her hair. She was more depressed when constipated and about the menstrual periods, and at times she had thoughts of suicide. Treatment by tonics, rest and proper outdoor exercise would stop the hair from falling, but the moment she became depressed the condition of the scalp was aggravated. No other hairy parts of the body were affected. There is nothing in the history (family or personal) that could account for the mental state, except that she was coddled and spoiled as a child and was allowed to be proud and vain.

In men the most frequently observed forms of hair-worry is in those who have acquired syphilis and who dread any slight increase in the loss of hair as an onset of that condition described in Timon of Athens, to "make the curl'd pate ruffian bald," as particularly to be dreaded from its revealing character.

This is especially the case in young men whose scalps are already affected with a mild steatoid pityriasis and who have paid little or no attention to the small daily loss of hair until, under the dread of specific manifestations, together with the toxic effect of the specific virus on the hair bulb, their worry becomes almost a monomania. Dr. Herman G. Klotz, in a paper¹ entitled "Remarks on Syphilitic Alopecia," emphasizes the points that loss of hair is not a common or regular symptom of the early stage of syphilis and that the slight loss of hair, which is constantly taking place in healthy individuals, as the result of the physiologic change of hair, continues its existence through and beyond the course of syphilis and must be taken into consideration before attributing to syphilis a loss of hair so slight as to pass unnoticed. In the discussion which followed, Dr. Robert W. Taylor said that he would classify the various types of syphilitic alopecia as follows: 1. Alopeciaphobia, by which he meant an ordinary *defluvium capillorum*, the danger of which was much magnified in the mind of the patient, who was afraid of losing his entire hair. 2. A shedding of the hair such as occurred in many adynamic diseases. 3. The moth-eaten, characteristic form of syphilitic alopecia occurring in spots. 4. An alopecia due to syphilitic lesions.

In these cases of hair-worry the patient should be told when there is an underlying steatoid pityriasis that this condition has nothing to do with the syphilitic process

1. Read before the American Dermatological Association at Cleveland, June, 1906, Jour. Cut. Dis., 1907, p. 99.

and will probably continue to cause a daily loss of hair even when the syphilis is thoroughly treated. In such cases an active local treatment will do much good. Many of these cases are not so entirely neurotic and it may be well at this point to briefly run over the causes of the hair falling out.

LOSS OF HAIR FROM GENERAL TOXIC CONDITIONS.

First, the loss of hair following febrile and severe constitutional diseases. The eruptive fevers, such as measles, smallpox, scarlet fever, have a more depilatory effect on the scalp in adults than in children, but all the severe infections, such as typhoid fever, pneumonia, pleurisy, erysipelas, peritonitis, grippe, mumps and even appendicitis, may cause a considerable falling out of the hair. Labor, even when normal and unaccompanied by fever, may be followed by a diffuse alopecia. According to Sabouraud, in all these cases there is a period of about eighty-five days intervening between the exciting cause and the loss of hair.

Alopecia due to syphilis may follow in two or three months after the secondary rash, or thinning out of the hair may not occur before the fifth to the eighth month. As a rule, this thinning out does not appear after the first year of the disease, but there is a form of syphilitic alopecia in patches which may develop in the second year of the disease. The typical specific alopecia in "clearings," as Brocq calls it, on account of its resemblance to the clearings in woods, occurs in the temporo-parietal and occipital regions and by its moth-eaten appearance is so pathognomonic that a diagnosis of syphilis may be often made from this alone.

General cachectic conditions due to tuberculosis, cancer, etc., also may act on the nutrition of the hair unfavorably and cause an alopecia. We have good grounds for considering all these cases to be due to the existence of a toxin in the circulation, a toxin which has a specific action on the hair bulb, and the extent of the depilation as well as the length of time before renewal of the growth varies with the severity of the disease causing the alopecia.

What are the grounds for this hypothesis? Experimentally, it has been shown that four doses of 0.08 gm. each of thallium acetate, a drug at one time employed to prevent the night sweats of phthisis, has caused a complete alopecia. This alopecia comes on fifteen to twenty days after absorption of the drug and appears first on the temples and back of the head and may progress in a few days to complete alopecia. Buschke² made a number of experiments on animals to see if the antagonistic effect of the thallium on the secretion of the sweat glands was the real cause of its producing alopecia. This theory had some plausibility, since pilocarpin, a stimulant of the sweat glands, has some reputation as an agent stimulating an increased growth of hair. He found from his experiments on animals that the antagonistic effect of thallium to pilocarpin on the sweat glands seemed to bear no relation to its depilating effect, but seemed to be due to some specific action on the hair bulb, and that the alopecia due to thallium acetate in animals, as in man, always began on either side of the median line of the head, face and back. He found also that external irritants elsewhere on the body could not induce alopecia away from this typical localization.

LOSS OF HAIR FROM LOCAL TOXIC CONDITIONS.

When we consider the loss of hair from local diseased conditions we at once encounter that great confusion of

authors regarding desquamative and seborrheic conditions of the scalp. Sabouraud has marked off the boundaries of this confused group through his histologic and bacteriologic studies. According to Sabouraud, the chronic dry exfoliation of the scalp in fine branny scales, the ordinary dandruff, is caused by the growth of the spore of Malassez—the "*Flaschenbacillus*" of Unna. This microphyte, although uncultivable, is found deep down in the loosened-up horny layers and is not found in other conditions. This dry pityriasis resembles very much in its chronicity pityriasis versicolor, the causal agent of which, the *Microsporon furfur*, although uncultivable, is never questioned. This dry pityriasis may last a lifetime without causing any marked loss of hair, but when it becomes greasy or steatoid the hair begins to thin out. This greasy condition may be due to one or both of two causes: a concomitant infection by the staphylococcus of porcelain-like growth, causing a serous exudation through the epidermic layers, or by the bacillus of oily seborrhea causing a hyperkeratosis in the mouths of the sebaceous follicles and a greatly increased flow of oil from the sebaceous glands, which chokes off and causes a shedding of the hair.

In man the process of becoming bald may be divided into three stages: First, the simple dry pityriasis or dandruff stage which in some individuals may last a lifetime without a marked baldness developing; second, that of steatoid pityriasis, in which the scales become greasy, more piled up and the hair begins to fall out more diffusely in periods of greater or lesser activity. New hair may continue to replace those lost, but the condition may pass on into the third stage of oily seborrhea in which there is very little scale formation, but the scalp becomes very oily and the hair falls more and more abundantly, being replaced by more and more downy growth until the typical hippocentric bald head is constituted.

In women the process rarely advances beyond the stage of steatoid pityriasis. The real oily seborrhea in women is only found in women of a masculine type.

The loss of hair due to ringworm and favus may be omitted on account of its extreme rarity in adults. I have seen a number of cicatricial alopecia cases in adults among immigrants from Russia and Italy, but never in native-born Americans. Any dread of hair loss among immigrants is not due to trichopathophobia, but purely from the dread of not being able to pass the medical inspection for admission to this country. Postfuruncular and postimpetiginous alopecia, as well as Brocq's pseudopelade, or *alopecia cicatricielle*, may also be passed on account of extreme rarity in adults.

Alopecia areata, however, is a type of *defluvium capillorum* which may cause really marked cases of trichopathophobia. In fact, I have seen in private practice both men and women seriously upset mentally by this form of hair loss. In nearly all such cases the dread seems to be due to the fear that they will be suspected of having syphilis. While, as has already been mentioned, this alopecia in areas may result from syphilis, either acquired or hereditary, syphilis is by no means the usual cause. Chronic tuberculosis and some change dependent on the menopause is given by Sabouraud as occasional causes, but the most of such cases are due to unknown causes.

Sabouraud's claim of an underlying infection with the bacillus of seborrhea and Jacquet's theory of nervous origin from peripheral irritation, oftentimes dental irritation, both seem to be insufficiently supported by facts. It is true that in all the cases coming under my observa-

2. Berlin klin. Wochschr., 1903, xxxvi.

tion there has been found a history of dental caries or toothache and that the cases always improved after the teeth were attended to, nevertheless, as local antiseptic and stimulating treatment was employed, I can not attribute all the good effect to the dental treatment alone. The frequency of alopecia areata is not at all in proportion to the great frequency of diseased teeth and other underlying causes must be sought for.

WORRY OVER THE COLOR OF THE HAIR.

This is not frequently met with, but certain shades of red seem to be particularly a cause of mental distress in young girls on account of the taunts of playmates. An amusing account of a peculiarly sensitive young man and his attempts to change the color of his red hair is given by Warren in his "Ten Thousand Pounds a Year." Through the use of various dyes and bleaches the color of his hair became as diversified as Joseph's coat, to the great chagrin, almost despair, of the hero.

WORRY OVER GRAY HAIR.

Worry is one of the usually given causes of prematurely gray hair. Cases of sudden blanching of the hair in one night are numerous and well authenticated. Metchnikoff³ refutes the opinion often expressed that this whitening of the hair is due to the penetration of air bubbles into the hair shaft. The change of color, he says, is due entirely to the loss of pigment caused by the sudden activity of cells in the medullary layer, which he calls pigmentophages or, better, chromophages. These chromophages leave the medullary or central portion of the hair and attack and absorb all the pigment granules within reach in both cortical and medullary layers. These cells then either wander back through the hair bulb or may pass out through the hair itself.

Metchnikoff says, also, that these pigmentophages are most active at night and that it is quite possible for them to blanch a hair in one night. This theory is not easily reconciled with facts shown by ringed hairs or the colorless hairs which first come in on a patch of alopecia areata and which later become pigmented.

Worry over the hair becoming gray, while common enough, rarely becomes a monomania. In some neuropathic women, however, this dread of appearing old drives them to use hair dyes in spite of harmful effects. Brocq⁴ describes such a case in a young American woman, neuropathic, prematurely gray, who, in spite of a severe dermatitis extending from head to foot which resulted from using a hair dye containing paraphenylenediamin, persisted in dyeing her hair until the last attack, attended by fever, required several months' rest in the mountains before recovery took place.

DERMATOPATHOPHOBIA IN HAIRY PARTS OF THE BODY.

Various forms of dermatopathophobia may have their localization entirely in the hairy parts of the body. These pruritic dermatoneuroses are common in users of morphin and cocain, and the dread is usually of parasites, such as pediculi, etc. Sometimes these unnatural sensations in hairy parts may develop into a *tic d'epilation*, or a mania for pulling out hairs. This trichotillomania is a morbid state constituted by pruriginous sensations in certain hairy parts of the body and an irresistible desire to relieve the distress by pulling out the hairs in the regions affected. The mustache is the commonest location of this tic in adults.

HYPERTRICHOPHOBIA, OR WORRY OVER HYPERTRICHOSIS.

Hypertrichosis in young women is the most frequent and most serious form of trichopathophobia with which we have to deal. All dermatologists have seen such cases. In certain neuropathic young women this excess of facial hair becomes such a fixed idea that the health may be seriously damaged by the loss of appetite, anemia, anxious, sad or melancholic state. The aversion to society and almost constant preoccupation of the mind about their deformity may develop into insanity.

Winfield⁵ found hypertrichosis in 78 out of 1,084 insane. "All but eight of these cases occurred in females. The eight men had thin and coarse beards, but their bodies were thickly covered with hair, especially marked over the spine. Twenty of the women had a copious growth of thick stiff hairs on their lips and chins. Most of the others had an unusually thick fuz all over their faces; all of them, however, had an abnormal amount of coarse hair over their bodies, thickest on the chest and back.

"One case illustrates how the mental condition seems to influence the growth of the hair; inasmuch as this appears to be unique, a full history will be given. The subject was a German girl, aged 24. Late in 1900 she had been admitted to the asylum suffering from an attack of acute melancholia; after six months she was discharged. Dr. Warren, who had charge of her, stated that while she was profoundly melancholic there seemed to be an increased growth of hair all over the body, especially marked on the face. She was readmitted in January, 1902, suffering from a relapse. Examination at that time did not reveal anything especially abnormal regarding the hair, except, perhaps, that she was a little more hairy than most females of her age.

"Her mental condition gradually grew worse until she went into profound melancholia. It was then noticed that the lanugo hairs all over the body were becoming thicker and stiffer. This change was most marked on the face, which rapidly became covered with a growth of fine blonde hairs, some being one-fourth to one-fifth of an inch in length. Her appearance at that time suggested a mild type of the 'Russian dog-faced boy.' After three months her mental condition slowly improved; simultaneously the superfluous hairs began to drop out, and on August 1 her face and body were as free from hair as when I first saw her."

I am indebted to Dr. Winfield for the history of a patient in his private practice who became insane on account of worry over hypertrichosis.

Patient.—Miss H. P., American, aged 20, large, well-developed girl.

History.—The girl had a high school education, but was unable to keep up with her classes on account of nervousness. At puberty (established at 14 years) a growth of fine hair appeared on the lip and side of the cheek. This troubled her so that she refused to go out, would not go to school, and spent most of her time crying. I was consulted regarding the removal of the hairs. She was unreasonable, had fixed delusions, obsessions, and in fact all the symptoms of insanity. The growth of hair on the face was just enough to unbalance the mind, which was already overworked. The parents had made an idol and fool of the girl, and the mental condition was the direct outcome of it.

If the hypertrichosis is very marked on the chin or upper lip or on the cheeks it becomes, of course, almost a

3. Etudes Biologiques sur la Vieillesse, Ann. de l'Inst. Pasteur, 1901, 865.

4. Bull. Med., March 13, 1898, 239.

5. Dermatoses of the Insane, American Jour. of Insanity, 1903, lix.

vital question for the patient to have the hairs removed, but many of these patients are worried over a mere downy growth to an extent that is far greater than the actual deformity justifies. Such cases must be reasoned with or prevailed on by suggestion, with perhaps the use of hydrogen peroxid to bleach the hairs so as to be less conspicuous.

The treatment of hypertrichosis by means of radiotherapy has not fulfilled its promise. Kienbock, Brocq, and Belot all agree that in the present state of our knowledge we are not in a position to produce a permanent alopecia with any degree of certainty, and in certain persons of great sensibility there is danger of producing permanent cutaneous lesions, such as scarring pigmentation, telangiectases, etc., which are more disfiguring than the hypertrichosis itself. Electrolysis therefore still remains the method of choice in these cases.

While the influence of precocious, perverted or arrested activity of the sexual functions may be given as causes of hypertrichosis, it does not follow that such women are sterile, in fact pregnancy, by its profound modification of the organism, may cause such hypertrichosis to disappear as in the very interesting case reported by Hyde and Montgomery in their Treatise on Diseases of the Skin. This case is all the more instructive in showing the effect of internal ovarian secretion, since the patient, a married woman, 33 years of age, weighing 150 pounds, mother of three healthy children, stopped menstruating for more than a year and had been pronounced by an expert to be past the climacteric. She applied for relief with a well-developed beard and mustache. During two years, repeated electrolytic séances were given to remove the superfluous hairs. Menstruation became re-established and continued irregularly, even menorrhagic at times; the hirsuties entirely disappeared. A year later she again conceived and gave birth to a healthy boy, the hirsuties at that time being entirely absent.

I have seen a slight hypertrichosis of the mammary areolæ also disappear under the effect of a pregnancy and remain permanently away.

Dr. Sherwell, before the New York Dermatological Society, stated that a profound modification of the organism, such as pregnancy, had been observed to cure a generalized and intractable alopecia. The internal ovarian secretion has an undoubted effect in stimulating the growth of sexual hair and cases have been cited which show that in woman the disturbed condition of ovulation has both caused an atrophy of hirsuties and has apparently stimulated the regrowth of hair in a case of total alopecia.

WORRY OVER THE LACK OF BEARD.

That the internal secretion of the testicles should be lacking in cases of removal of the testicles or in cases of undescended or atrophic testicles, seems to be attested by the absence of or scanty beards of such individuals. Quite naturally certain young men in whom there is a tardy appearance of beard worry a great deal over this lack of what they consider the badge of virility. Some of these cases, due to the above mentioned causes, are beyond relief, but suggestion and counter irritation may do much towards reassuring the worry over the absence of a beard in young men who, though having nothing the matter with the testicles, are comparatively devoid of beard.

50 West Thirty-seventh Street.

THE FREQUENCY, MORTALITY AND TREATMENT OF PLACENTA PRÆVIA.*

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The frequency of placenta prævia is variously stated at from 1 to 1,000 to 1 to 250 cases. It occurs six times as frequently in multiparæ as in primiparæ. We can readily understand, in view of this difference, how in the statistics of an indoor service in which most of the patients may be unmarried primiparæ the first proportion might exist, while in statistics from a consulting obstetrician's practice the lower ratio would prevail. In my outdoor charity service, in which 87 per cent. of the women confined were multiparæ and the average number of pregnancies was more than four for each woman, in 1,800 cases placenta prævia occurred eight times, or 1 to 225. As there is practically no means of prophylaxis, the advance of the art of obstetrics has not reduced the frequency of this complication.

THE PROGNOSIS.

In prognosis we find that there has been a constant improvement, and we may view with relief the recent statistics in comparison with the older records in which the maternal deaths were as many as 30 or 40 in the 100. Sepsis, of course, was the chief cause of the earlier high death rate. But, in addition to the introduction of asepsis, improvement in the methods of management has accomplished a great deal toward lowering the mortality.

Current literature gives evidence that there is not a uniform opinion as to the present mortality. From different viewpoints we find that placenta prævia is looked on differently. The confidence engendered in the highly skilled obstetrician who, armed with vast experience and surrounded in his hospital with perfect equipment and trained assistance, may approach these cases with *sang froid*, leads him to minimize the dangers of this accident. But we still find practitioners at large reporting their isolated cases in a manner which indicates that they were formidable events in their obstetric experience. The general practitioner who comes without warning and without assistance on a case of placenta prævia and finds the woman already far gone from hemorrhage has a terrific ordeal before him. Yet we find in a standard text-book of obstetrics the statement: "With the treatment just described, carried out by men who understand aseptic methods, the mortality almost disappears."

Hirst selected several series reported by men whose results had been especially favorable, and generalizing on these figures many writers, in discussing modes of treatment, have recently referred to the accepted mortality of placenta prævia as about 1 per cent. De Lee¹ reported one death in a series of thirty cases, but said "a woman with placenta prævia ought not to die except in rare cases, such as air embolism or the hemorrhagic diathesis." While approved methods have brought about a greatly improved prognosis, I do not think that the tendency to make light of placenta prævia as a serious complication is justified by the facts nor that the few most favorable series should be made the basis of an accepted death rate. After studying many recent statistics from hospitals and private sources, I believe I should state the mortality as follows: In the hands of

*Read before the Section on Obstetrics and Gynecology, New York Academy of Medicine, Oct. 24, 1907.
1. Placenta Prævia and Its Treatment, Int. Clin., 1906, iv, 220.