

should maintain its normal ratio of 2.3 with the systolic pressure.

The writer believes that increased systolic pressures indicate the presence in the circulating blood either of unexcreted putrefactive products absorbed from the intestine, from the kidneys, from focal infections in the dental alveoli, the nasal sinuses, the tonsils, the genito-urinary tract, or of secretions in abnormal amounts from the glands of internal secretion. This is also held to be true of the diastolic pressure when it does not maintain its normal ratio to the systolic. Lowered systolic and diastolic pressures are due to deficient delivery into the blood stream of pressor substances or increased delivery of depressor substances. Neither systolic nor diastolic pressure gives any indication regarding renal or myocardial condition. When hypertension and cardiorenal disease occur together, they are believed to be secondary to the same primary causes mentioned above, and not secondary one to the other.

*The Salicylates. X. The Specificity of Salicylate in Rheumatic Fever.* Paul J. Hanzlik, R. W. Scott and P. C. Gauchat, Cleveland, Ohio. The Journal of Laboratory and Clinical Medicine, Vol. 4, No. 3, December, 1918, p. 112.

The alleged specificity of salicylate in rheumatism was tested by comparing the therapeutic effects of agents chemically different from, but pharmacologically similar to, salicylate. Patients suffering with rheumatic fever were at first given combinations of an antipyretic (quinin) and an analgesic (morphine), using rather large doses in accordance with the principle of massive doses of salicylate in this condition. If no relief followed, salicylate was administered to "toxicity" in the usual way. When complete relief followed the administration of the non-salicyl combinations, no further administration of salicyl was used, and from this it would logically follow that salicyl is unnecessary and its alleged specificity in rheumatism is unfounded. This series of patients was also compared with a series receiving salicylate alone without previous medication.

The acute symptoms of rheumatic fever were found to be promptly and effectively relieved by combinations of antipyretics and analgesics chemically different from salicylate. If to this are added the favorable reports of others obtained with foreign proteins and rest alone and the numerous recurrences of the disease after repeated treatment with salicylate in large doses then salicylate possesses no thoroughly demonstrated specific action in rheumatic fever. The view expressed by the authors is that salicylate is no more than a symptomatic remedy, which

can be safely administered in very large doses, and represents a fortunate combination of both antipyretic and analgesic qualities. The unwarranted and promiscuous use of the drug should be restrained, since it has been shown that salicylate possesses an injurious effect on the kidney and its functional efficiency.

*Meningitis.* Hyman I. Goldstein, Camden, N. J. New York Medical Journal, Vol. 109, No. 18, May 3, 1919, p. 760, and May 10, 1919, p. 803.

Differential diagnosis of meningitis is very important and should be made early, so that antimeningococcic serum (polyvalent) can be given with the hope of saving life in cases of meningococcic meningitis (epidemic cerebro-spinal meningitis). It is important to know that the early diagnosis can be made certain by the thorough examination of the patient, and that atypical cases may occur.

The serum should be given intraspinally and intravenously, because in the pre-meningitic stage the blood contains the meningococci just as in any other septicemic (bacteremia) condition and the actual metastatic involvement of the meninges may thus be warded off. Serum should be given daily for at least four doses. It does no good when administered subcutaneously. It is advisable often to use the serum of several firms, as in some cases no favorable result is obtained because of different strains of meningococci.

Hexamethylenamin or urotropin requires an acid medium for its action and the cerebro-spinal fluid is alkaline. Injection of oxygen or air intrathecally may be tried. Early lumbar puncture, and frequently repeated, does good even in tuberculous cases, and in those other types of meningitides for which there is no specific serum.

Dial (Ciba); barbital; morphine and atropine hypodermically ease the pain and afford some rest and sleep for the patient. Caffeine and brandy may be given for stimulation. No strychnine should be used.

The examination of the cerebro-spinal fluid is to be done in every case where meningitis can not be ruled out.

Differential diagnosis must be made from tuberculous meningitis, typhoid fever, sinus thrombosis, encephalitis lethargica ("nona"), malaria, hysteria and acute anterior poleomyelitis (Heine-Medin's disease).

Other important signs and symptoms are the Kernig sign, Brudzinski's sign, Trousseau's sign, Squier's sign, contralateral reflex—associated with or without early projectile vomiting, slow pulse, and severe headache.