

## RELATION OF ALBUMINURIA TO INDICANURIA

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From the records of 500 specimens of urine examined in the clinical laboratories of the Medico-Chirurgical and Jewish Hospitals, during 1909 and 1910, including specimens from my own practice examined in my office, I find an apparent definite relationship existing between the occurrence of albumin and indican. I could find no previous record of such relationship in the standard works on clinical urinalysis. The following tabulation will illustrate the matter clearly:

	No. of Specimens
Albumin reaction, but no indican.....	187
Indican reaction, but no albumin.....	210
Albumin reaction with questionable trace of indican .....	4
Indican reaction with questionable trace of albumin .....	2
Neither albumin nor indican reaction.....	97
Total examined .....	500

This illustrates that it is not common to find albumin and indican present in the same specimen of urine, and when present, either one or the other will usually exist in so minute a quantity as to give a questionable reaction with the usual tests.

The tests used for the detection of albumin were those usually employed in the above-mentioned laboratories, namely, (a) the nitric acid contact test; (b) the heat test, and (c) contact test with Roberts' solution.

The test employed for the detection of indican was the procedure described by Daland, i. e., to 10 c.c. of filtered urine add 1 drop of a 1 per cent. solution of potassium chlorate, then 5 c.c. of chloroform, and lastly 10 c.c. of chemically pure hydrochloric acid, to be mixed thoroughly by pouring repeatedly from one test-tube to another. Within two or three minutes the indican, if present, is reduced to indigo, which dissolves in the chloroform and imparts a blue color to it. In about ten minutes the maximum coloration is reached.

The apparent relationship between albuminuria and indicanuria is a question to be solved.

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## TWO CASES FROM CESAREA

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## REPEATED REFORMATION OF STONE IN BLADDER

**Patient.**—A Greek, aged 76, in good general condition, presented himself at our clinic, complaining of painful micturition, stranguy and often blood-tinged urine. Examination showed suprapubic scar and perineal scars; examination of bladder showed presence of stone.

**History.**—In August, 1905, patient was first operated on for stone in the bladder, through the perineal incision. The operation was performed at Talas American Hospital by Dr. Post of Beirut; and, according to patient's account, a very large, hard, nodular, irregular-shaped stone was extracted. The second operation for stone in the bladder was performed January, 1906, when a small bird's-egg-sized stone was extracted. The patient says that both perineal and suprapubic incisions were made. The third operation was one year later; through perineal incision, and a stone the size of an olive was extracted.

**Operation.**—The fourth operation was performed after an interval of four years, on Nov. 23, 1911, at the Talas Hospital, by the perineal route. A bird's-egg-sized stone was extracted and the patient made an uninterrupted recovery.

## ACCIDENTAL COMPLETE INVERSION OF UTERUS

The status of midwifery practice in Turkey is well illustrated by the following case:

**Patient.**—A young American woman from the city of Cesarea came to us complaining of an almost continual hemorrhage since the birth of her child four months previously. Examination showed a well-formed woman, aged 20, extremely

anemic; mucous membranes and conjunctivæ showing pale and bloodless. Local examination revealed a completely inverted uterus, contracted to normal size, firm in consistence, lying entirely within the vaginal cavity; the slightest manipulation caused blood to ooze from the exposed mucous membrane of the uterus.

**History.**—On being questioned the patient told the following story: "I had been well throughout this pregnancy, and, not anticipating any trouble, did not consult any physician but when labor pains came on I called a midwife to assist me. She made the usual examination and assured me that all was right and told me to have no fear. I brought forth my child with considerable difficulty, after which the midwife made another examination, and to my consternation said that there was a second child. She then tried to force the child out by pressing forcibly on my abdomen, but when that failed she began pulling at something from below. She pulled and pulled until she found it impossible to accomplish anything, when, on more careful examination, she found that what she was pulling at was no child at all, at which she became frightened, and, saying she could do no more, she left me to my fate. I did not realize what had happened but knew that something was wrong and I almost died from the effect of the ordeal through which I passed. Finally, after some weeks, I recovered somewhat but found that the hemorrhage continued and I decided to come and consult you."

**Operation.**—Median abdominal incision was made in the hope of being able to dilate the cervix forcibly and replace the uterus, although after a lapse of four months it was considered very doubtful. The cervix was found rigid and unyielding and after a few minutes' effort the replacement of the uterus was abandoned. The tubes and round ligaments were disposed of through the abdominal incision, after which the hysterectomy was completed *per vaginam*. The patient made an uneventful recovery, leaving the hospital in eighteen days.

The midwives of this country are for the most part untrained women who know little of the principles of asepsis, and in practice disregard them entirely. As a consequence puerperal fevers and pelvic trouble of all kinds are very common.

## New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLE HAS BEEN ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION. ITS ACCEPTANCE HAS BEEN BASED LARGELY ON EVIDENCE SUPPLIED BY THE MANUFACTURER OR HIS AGENT AND IN PART ON INVESTIGATION MADE BY OR UNDER THE DIRECTION OF THE COUNCIL. CRITICISMS AND CORRECTIONS ARE ASKED FOR TO AID IN THE REVISION OF THE MATTER BEFORE PUBLICATION IN THE BOOK "NEW AND NONOFFICIAL REMEDIES."

THE COUNCIL DESIRES PHYSICIANS TO UNDERSTAND THAT THE ACCEPTANCE OF AN ARTICLE DOES NOT NECESSARILY MEAN A RECOMMENDATION, BUT THAT, SO FAR AS KNOWN, IT COMPLIES WITH THE RULES ADOPTED BY THE COUNCIL.

W. A. PUCKNER, SECRETARY.

**ATOPHAN.**—Phenyl-quinolin-carboxylic-acid.—Atophan is 2-phenyl-quinolin-4-carboxylic acid,  $C_{16}H_{11}N.O_2$ .

2-phenyl-quinolin-4-carboxylic acid was described by Doebner and Giesecke in 1887 (*Annalen der Chemie-Physik*, Vol. 242, p. 291), who prepared it by warming together pyroacetic acid, benzaldehyde and anilin in alcoholic solution. Its therapeutic action was described by Nicolander and Dohrn in 1908 (*Deutsches Archiv für Klinische Medizin*, Vol. 93, p. 331).

Atophan crystallizes in small colorless needles, melting at  $208^{\circ}$ – $209^{\circ}$  C. It is insoluble in water but readily soluble in alkalies, hot alcohol and boiling glacial acetic acid. It has a slightly bitter taste.

**Actions and Uses.**—Atophan in doses of 0.25 to 0.5 Gm. (4 to 8 grains) increases uric acid excretion, within one hour. In doses of 2 to 3 Gm. (30 to 45 grains) the normal average uric acid excretion is doubled and sometimes even trebled in twenty-four hours. This action of atophan is said to occur both under purin-containing and purin-free diet. Its influence on uric acid excretion is stronger and more prompt than that