

from the evidence furnished by this group of Massachusetts physicians, each more or less intimately connected with tuberculosis work, as well as from these 200 patients of my own, who, as by far the greater number were sent to me in consultation and all were seen at my own office, were probably scrutinized with considerable care?

In the first place, it is clear that no hard and fast ruling can be made as to the diagnosis of early pre-bacillary tuberculosis. Each case must be considered on its own merits, and the signs and symptoms present, whether constitutional or local, carefully weighed and compared with those that are not present. In a certain number of cases, however, as shown not only from my own records but from the written opinion of a fairly representative group of physicians in this state, a definite diagnosis can and should be made in the absence of either constitutional or local signs and symptoms. In the vast majority of instances, a combination of both will be found present after careful study.

In regard to cough with or without sputum, a combination considered almost essential to the diagnosis of tuberculosis in any stage, my own cases show the remarkably high proportion of 107 out of 200 cases, or 53 per cent. apparently without either cough or sputum. Perhaps this high figure is only a coincidence, while in addition, it is evident that a considerable number without history of cough or sputum were hemorrhage cases whose chests were only superficially examined on this account. I believe, however, that this large group simply goes to show that not even what were considered the most classic earmarks of consumption are necessarily present in its early stages. This same point is emphasized by the fact that out of 200 cases there were 69, or 34.3 per cent. without local signs in the chest such as dulness, altered breath or voice sounds, or râles. The average fourth year medical student, if he has any clear idea at all in his mind as to what constitutes incipient pulmonary tuberculosis, certainly includes in it a history of cough and sputum, and certain signs in the lungs, such as dulness, altered breath sounds, or râles. That these were absent in over one-third of 200 patients is interesting and instructive.

The most important point, in my opinion, to be gathered from the experience of this group of physicians as expressed in their replies to my questions and from a study of the 200 cases from my own records, is the necessity of putting entirely out of one's mind any preconceived picture as to what form incipient pulmonary tuberculosis should take, or of any definite group of symptoms, local or general, it should possess. Hemorrhage may or may not be present; cough and sputum are not necessary accompaniments; signs in the lungs may be lacking; the temperature may be high or subnormal; a rapid pulse is not always present, nor is a history of loss of

weight or strength or energy always to be obtained; in fact, no one or no two signs or symptoms are essential to a correct diagnosis.

Common sense, patience and painstaking thoroughness on the part of the doctor are the true essentials in arriving at the truth. It is more what the physician has in his head, and less what the patient has in his lungs on which the correct diagnosis and the patient's life depends. The stethoscope used less and the thermometer and common sense used more, would vastly better the present state of affairs, while of still greater benefit would be the imparting of these facts to our medical students who now have to wait until sad experience and unnecessary tragedies in the early years of their practice have taught them these essential points.

MORPHINE-ATROPINE, PITUITRIN AND ETHER IN OBSTETRICS.

BY JOHN F. MARTIN, M.D., BOSTON.

ANY method, in itself safe, which will alleviate the suffering and promote the termination of labor, is an aid both to the accoucheur and the parturient woman, particularly in cases where, for one reason or another, delivery is delayed.

Normal delivery ensues when labor terminates without accident to mother or child, prolonged delay, or instrumentation.

As labor is attended with concomitant pain, and often delay incident to disproportion, insufficient uterine contractions, rigid soft or bony parts, relief given to the patient is welcomed by her.

Dulling the sensory mechanism of the gravid uterus and overcoming cervical rigidity with such drugs as morphine, bromides, chloral, veratrum, and ether have their place, and their indications are known to the usual obstetrician. In easy, or purely normal deliveries, they are often made use of as in the fore-mentioned indications, and are of help, though sometimes a hindrance if unguardedly given.

The vogue of "twilight sleep," promulgated through press, home, and pulpit by the adherents of the morphine-scopolamine method of obstetrical treatment has received its numerous knocks from the advocates of conservative and safe therapeutics.

Allow a puerperal woman to become acquainted with a method which will obtund the sensation of pain, she is likely to mention the desirability of its use to her physician. It is for him to choose a procedure without endangering the safety of mother or child.

The increased risk of the "twilight" method is sufficient to make its use unappealing when the physician's armamentarium contains such

aids as morphine, pituitrin and ether. The marked susceptibility of some women to morphine-scopolamine medication, due principally to the effect of scopolamine, should deter one from too often using it, if at all.

It is the inherited right of every parturient woman to be given the most skillful, considerate, and mitigating attention by her physician, free from the inconsiderate use of forceps—often the result of impatience.

Enough has been written about the physiological effect of scopolamine (hyosine) to make the average physician conversant with its action. The objection to its use comes from its untoward effect upon both mother and child. Its depressing effect upon the respiratory centre tends to cause a lowering of the oxygen content of the blood, and such consequential calamities as asphyxia livida cannot be entirely due to the maternal depressive action of the compound, morphine-scopolamine, but also to fetal somatic inhibition.

It prolongs the second stage through its relaxing effect upon the uterine muscle, tending to post-partum hemorrhage; idiosyncrasy to the drug induces delirium, throat dryness, and muscular tremors, often alarming while they last. Why jeopardize safety for the sake of novelty?

A few women bear labor without much discomfort, others require a degree of sedation or relaxing, while the usual puerpera accepts pain amelioration with gratitude.

Morphine-atropine, the components of which are synergistic as well as antagonistic, produces sensory sedation, and given once or twice during first stage is of help, and the usual procedure.

The active principles of the posterior lobe of the pituitary gland, embodied in pituitrin and similar preparations, have demonstrated their usefulness in obstetrics through the physiological effect produced. The oxytocic action of pituitary products is due to the effect produced upon the uterine muscle in promoting contractions. Increased vascular tone, intestinal peristalsis, and diuresis are synchronous effects and assist the action of the principal means, as well as aiding to post-partum comfort.

Pituitrin should not be given during the first stage of labor, as it is distinctly contraindicated on account of the danger of uterine rupture, premature detachment of the placenta, and fetal strangulation. The time to give pituitrin is when the os is fully dilated, the presenting part engaged, with primary or secondary inertia, and the position anterior occiput.

From five to fifteen minutes after an injection of pituitrin is given subcutaneously, or intramuscularly, uterine contractions become more active, reaching the acme of continuous contraction. If the soft parts are not resistant, delivery is quite rapid; if resistance is met, the force behind must overcome it, then obstetrical ether, and holding back the head, prevents too rapid divulsion and laceration.

Some writers advise giving pituitrin when the head is engaged and the os admitting one or two fingers. It seems such procedure is permissible only in the absence of disproportion and soft os present.

Ether, given during the second stage of labor, induces a comforting degree of analgesia when inhaled at the onset of each pain; and, if the pains are strong, full anesthesia, as the head descends on the perineum, obtunds the consciousness so that, in many cases, birth is not felt at all. It is a far safer and better analgesic than the narcotic alkaloids during the second stage of labor.

Such an ideal result is often hampered by the relaxing of uterine contractions, due to the paralyzing effect of the anesthetic, particularly when a degree of inertia is present. Pituitrin given in such cases works well, hastens delivery, and allows full anesthesia during descent and birth of the presenting part.

A gush of blood often follows birth of child, due to "squeezing out" of uterine muscle. The after-birth is usually delivered more rapidly, and the patient goes through her delivery without untoward event.

Obstetrical ether alone, when contractions are good, is often sufficient; plus pituitrin, or similar preparations, when contractions are weak, and not contra-indicated, gives to them the deserving cognomen of "artificial forceps."

Clinical Department.

SUCCESSFUL USE OF INTERNAL SPLINTS IN A SEPTIC COMPOUND FRACTURE.

BY PEIRCE HENRY LEAVITT, M.D., BOSTON,

Resident Surgeon, Boston City Hospital.

[From the Wards of the Second Surgical Service,

F. B. LUND, M.D., Chief of Service.]

THIS case is reported in order to register the successful use of a bone plate in a septic compound fracture of the lower leg, and the value of constant irrigation, and the subsequent use of direct sunlight.

The patient, male, 34, laborer, while unloading heavy pieces of machinery, was struck on the right lower leg by a piece of machinery and sustained a compound fracture of the tibia at about its middle, a fractured fibula and fractured astragalus. The wound on the skin was not a ¼-inch long.

There was also in this region a large abrasion of the skin, about the size of one's hand. The fracture was treated conservatively; that is, the