

DR. C. B. LOWE, Germantown, Pa., said that he did not wish to bring any reflection on the New Haven Hospital, and as Dr. Osborne qualified his statement, he would like to amend his own by saying the New Haven Hospital and others.

DR. HENRY R. SLACK, LaGrange, Ga., twelve years ago spent some time visiting hospitals and investigating their methods. The internes, the hospital men, were all bright young fellows who spent an hour or two making careful diagnoses by blood counts, analysis of urine, etc., but they did not know what to prescribe. The chiefs, on having their attention called to this state of affairs, said they did not have time to write prescriptions. Dr. Slack found that true in Philadelphia, in Baltimore and in Chicago. That, he said, is the seed, the germ from which these proprietary remedies spring. Bright men pass examinations, take positions as internes and yet they do not know what medicines they are prescribing. The average graduate when he begins to practice snaps up the first proprietary that comes along as a fish does bait. That is the reason the proprietary men have such a rich field. Dr. Slack urged that we teach the young members of the profession to write prescriptions, know what medicines they are using, and not depend on some one else to furnish prepared panaceas for all the ills to which flesh is heir.

INTRAVENOUS TREATMENT OF SYPHILIS.

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My clinical experience with the intravenous injection of mercury in syphilis is as yet limited. I nevertheless feel warranted in presenting that experience to the profession. I confess that it was with some hesitancy that I adopted the method. I have, however, been pleased with my experience thus far. I herewith submit a report of ten cases in which I have used the intravenous injection with mercuric chlorid. It will be understood that I do not claim that the intravenous method was the only one available in all these cases, nor am I yet in a position to assert that it should be used as a routine practice. In several, however, it was a most valuable therapeutic resource, and in all of them its action was superior to that of any other method in my experience. In "malignant" cases and lesions that seriously menace the integrity of the nervous system or viscera, intravenous injections would appear to afford a safe and sure method of relief. The speedy mercurialization of the blood with consequent prompt systemic effect of the drug, the relatively large doses permitted, the freedom from the painful effects of subcutaneous and intramuscular injections, and in general the absence of gastrointestinal disturbances, especially commend the intravenous treatment. Judging from the small series of cases herewith appended, bowel irritation is exceptional from the use of large doses of mercury intravenously. There is apparently no tendency to sudden severe salivation from the intravenous use of large doses of the drug, although the mouth reacts promptly in some cases.

CASE 1.—A woman, 30 years of age, in the beginning of the third year of typical secondary syphilis. Pains in the limbs, lowered tendon reflexes, and a sensation of numbness and heaviness of the limbs were complained of at the time I was first consulted, and the patient stated that she had had these symptoms for several weeks. There were no other symptoms suggestive of ataxia. There was a slight apparent loss of muscular power over the lower extremities. I put the patient immediately on intramuscular injections of succinamid, but she proved intolerant of them, the pain being so severe that I was compelled to discontinue their use. Inunctions produced a severe dermatitis, and mercury internally resulted in severe

gastrointestinal irritation, the stomach becoming so sensitive that I was compelled to discontinue medication by the mouth. The indications for radical treatment being urgent, I resolved to try the intravenous injections, giving 25 minims of a 1 per cent. solution at a single daily injection for two weeks. Improvement was noted after the third injection, and the cord symptoms entirely disappeared at the end of ten days. The emergency having apparently passed, and the stomach being again tolerant of drugs, I stopped the intravenous injections and put the patient on the routine administration of protiodid.

CASE 2.—Woman, 23 years of age, with a gummy ulcer of the right ala nasi. Aside from this single tertiary manifestation of the disease, no lesions had been noticed for several years. The nasal ulcer proved very resistant to treatment. It yielded slowly, and when cicatrization had been complete for a few days, the lesion suddenly, without a warning, would recur. Mercury and iodid pushed to the point of tolerance had yielded only temporary benefit. The patient was a large, well-nourished woman, and I began with fifteen drops daily of a 2 per cent. solution of bichlorid. The curative effect of the method was very quickly noted. The ulcer healed soundly within ten days and has remained healed for over a month, during which time the injections have been given twice weekly.

CASE 3.—Young man, 33 years of age. This was a rather unusual case, being one of chancre of the tonsil. The primary lesion was associated with an enormous cervical adenopathy on the left or corresponding side. The faucial inflammation was very marked. Mercury given by inunction and by mouth acted extremely slowly in this case, and as deglutition was very painful, the patient complained very bitterly of his condition. I began intravenous injections of bichlorid in a dosage of 15 minims of a 2 per cent. solution. I did not go beyond the dosage for the reason that I was apprehensive that the large amount of mercury that had already been given in the ordinary way might suddenly take effect and in combination with the intravenous dosage produce disastrous results. Within four or five days after beginning the intravenous injections marked improvement was noticeable, and resolution of the primary lesion and of the bubo in the neck went on very rapidly.

The physiologic effects of the mercury were manifest on the tenth day, and the treatment was discontinued. The improvement, however, went steadily on, and at the end of three weeks the patient was in a very satisfactory condition.

CASE 4.—Patient, a man, 35 years of age, had been under my treatment for syphilis for about five years, the case being a very stubborn, protracted one. Various lesions had appeared from time to time, and had healed only after very large doses of mercury and iodid, long-continued. The patient had been under tonic doses of mercury constantly for a period of six months, during which he had been apparently well. He suddenly reappeared, however, for advice, presenting a gumma of the soft palate. This softened, broke down, and perforated within forty-eight hours. It appeared so malignant that I resolved not to rely on antisyphilitic remedies administered in the ordinary manner, and therefore put the patient on intravenous injections, using 20 minims of bichlorid, 2 per cent., daily. Marked improvement was manifest at the time the third injection was given. A permanent fistula will undoubtedly result in this case, but the destruction of tissue was speedily checked and the process limited to an area very much smaller, in my opinion, than would have been the case with any method of treatment other than the intravenous.

CASE 5.—Woman, 40 years of age, under treatment for locomotor ataxia undoubtedly of syphilitic origin. This case was very difficult of management because of the intolerance of the stomach for mercurials and iodids, and the extreme irritability of the skin, which practically prohibited inunction treatment. Some improvement in the symptoms was noted soon after the routine administration of mercury, but exacerbations of severe pain in the lower extremities continued to be a frequent and annoying symptom, and as it was impossible to continue the treatment for any length of time, the case was especially trying. Intravenous injections of $\frac{1}{4}$ grain doses of bichlorid of mercury produced rapid improvement. The patient is now

taking the injections twice a week, and the case is apparently under control.

CASE 6.—Man, 45 years of age, suffering with a severe and obstinate cephalalgia of syphilitic origin. Mercury and the iodids were pushed to the point of tolerance, with but slight relief. I substituted the intravenous injections, administering bichlorid in half grain doses daily for one week. Relief was immediate. At the end of the week the headache had disappeared entirely. Injections are now given semiweekly.

CASE 7.—Man, 50 years of age, whom I had treated for syphilis twenty years before, reported to me suffering with nocturnal headaches and cerebral symptoms which were decidedly suggestive of an incipient paresis. Lack of concentration and suspicion were noted, and the impairment of his psychic faculties had given rise to considerable alarm on the part of his friends. Gastric irritation and constipation were prominent symptoms, and the evident presence of autointoxication as a complication gave the case a much more favorable aspect than it would otherwise have possessed. The patient absolutely refused to submit to inunctions, and as the stomach proved intolerant of mercury and the iodids I resolved to try the intravenous method. Restoration of the bowel function was first attempted, with gratifying results, the mental symptoms improving markedly within a few days. The headaches, however, continued. Daily intravenous injections of $\frac{1}{4}$ of a grain of bichlorid were then begun. The headaches began to improve within three or four days after beginning the treatment, and within two weeks had entirely disappeared. For six weeks, during which time the patient has been taking no treatment, he has remained apparently well. He will not submit to steady treatment, but has promised to take a course of intravenous injections several times yearly.

CASE 8.—A delicate woman, 28 years of age, without a previous history of syphilis, presented herself with two painful nodes on the right tibia. Nocturnal pains were very severe, necessitating administration of morphin by her previous medical adviser. She had been given small doses of mercury and iodid of potassium without effect; large doses were not tolerated. The patient was put on daily $\frac{1}{8}$ grain intravenous doses of the bichlorid, with the result that within a few days the osteocopic pains ceased and the nodes markedly diminished in size. Slight permanent thickening of the bone at the affected points, however, resulted. This patient is now taking semiweekly intravenous injections of $\frac{1}{8}$ grain of the bichlorid, and is apparently doing well.

CASE 9.—A patient, whom I thoroughly treated for syphilis fifteen years before, reported, complaining of severe pain in the tibiae of some six weeks' duration. The pain was especially marked at night. Examination showed a diffuse periostitis over both tibiae, with slight thickening of the membranes, some edema and exquisite tenderness on pressure. I at once began the intravenous injection of bichlorid, in $\frac{1}{2}$ grain doses. When the patient reported for the second daily injection, he stated that the bone pains had disappeared within three or four hours after the first treatment. Within five days, during which time the intravenous treatment was given daily, the tenderness of the tibiae entirely disappeared. On the sixth day I began interrupting the treatment because of slight ulceration, evidently of mercurial origin, of the mucous membranes of the cheeks. It is now five weeks since the systematic daily treatment was suspended, during which time injections have been given twice weekly, and there has been no recurrence of the pain in the limbs, and no disagreeable effects from the drug.

CASE 10.—Physician, 40 years of age, reported with a chancre of the right finger, with a well-marked typical secondary papular syphilide. Time being an important consideration to the patient, intravenous injections of $\frac{1}{4}$ grain doses of bichlorid were immediately begun. Improvement was manifest within three days, the obscure bone pains with which the patient had been suffering having disappeared, and the eruption having already begun to fade. The intravenous injections were continued for ten days, and, the case being apparently under perfect control, were replaced by inunctions. The patient is still under treatment, and doing well. He has had considerable experience in the management of syphilis, and characterizes the progress of his case as marvelous.

REMARKS.

Granting that the intravenous method of administration of mercury is safe, it would seem to be a very valuable addition to our armamentarium therapeutikum in the treatment of syphilis. I have no hesitancy in saying that it is possible with safety to bring the patient under the full physiologic effect of mercury within forty-eight hours. Argument is unnecessary to prove the value of the treatment in certain emergencies. When carefully given, accidents should be infrequent. I am convinced that where the entire dosage is accurately placed within the lumen of the vein no reaction whatever will occur, providing the tourniquet be moved from the arm after the insertion of the needle into the vein and before the discharge of the mercurial solution has begun. I failed to remove the tourniquet in Case 5, with the result that the portion of the vein between the tourniquet and the needle was practically cauterized, with a resulting phlebitis. This passed away in a few days and left an indurated vessel, which is probably useless for further injection. In Case 10 considerable inflammation resulted on one occasion at the site of the injection. In this case I am confident that I perforated the posterior wall of the vein, thus permitting a few drops of the injected solution to enter the perivascular cellular tissue.

As to the location of the injections, either the median basilic or median cephalic vein in the forearm is an eligible site. The accessibility of these veins, however, varies, and some other site must sometimes be selected. I have found that any prominent and accessible vein will answer the purpose.

A PLEA FOR THE PHYSICAL EXAMINATION
OF ALL SCHOOL CHILDREN.

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Education is compulsory in this country for all children from the ages of 6 to 14. In some states the duration of school life is longer. If the child is not presented by its parents for instruction, the parents must present some good excuse for its non-appearance; and social reasons are not accepted. There are numerous chronic ailments of childhood which absolutely prevent or militate against its receiving any instruction. The more important of these are serious congenital mental defects and defects of the heart or organs of speech. There exist, also, many minor defects, eradicable, provided the parents are informed that such defects exist. The existence of the minor defects, such as squint, near-sightedness, adenoids, enlarged tonsils, bad teeth, nervous twitches, and so on, are often not discovered by the parents, nor is their seriousness realized until the child has for some time been under the influence of school life.

In March, 1905, the medical inspection became a medical examination of school children in New York. Up to January, 1907, 134,000 children had been examined. These examinations consist in examinations for hearing, vision, examination of the nose and mouth for the presence or absence of deformities and the examination of the heart and lungs as much as can be made by loosening the clothing at the neck. No measurements or weights are taken. The findings show an enormous proportion of minor defects and also a considerable proportion of more serious ones.