REMARKS ON SOME SPECIAL CHARACTERS OF THE PRESENT EPIDEMIC OF TYPHOID FEVER IN LONDON.

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THE enteric fever prevalent in London during the last three months, September, October, and November, so far as I have seen or heard of it, has had certain features which, from a practical point of view, it seems desirable to notice while the epidemic is still prevalent. The characters to which I allude are these: the high rate of mortality, the liability to relapse, the prolonged duration of the fever and of the convalescence, the proportion of patients whose recovery was delayed or prevented by intercurrent inflammations, and, most of all, the insidious and misleading nature of the early symptoms.

By the favour of my colleagues, Dr. Fincham and Dr. Allchin, I am enabled to enumerate twenty-one consecutive examples of enteric fever admitted into hospital during the period specified. They are as follows: 1. Henry C., 39; died on the 21st day. 2. James A., 22; died 37th day after relapse. 3 and 4. Ernest C., 5½, Alfred C., 8; brothers, children of No. 1; good recovery. 5. George H., 34; died 56th day after relapse. 6. William S., 24; admitted October 26th; not yet convalescent. 7. Jane B., 19; admitted October 17th; not yet convalescent. 8. Mary C., 8; admitted September 28th; relapsed; still in hospital. 9. Richard H., 17; good recovery. 10. Georgina P., 8; slow convalescence and great wasting. 11. John M., 23; good recovery. 12. John A., 16; good recovery. 13. Charles A., 20; died on the 28th day. 14. Frank P., 20; admitted September 20th; prolonged pyrexia; still in hospital. 15. Sarah P., 19; slow convalescence; over two months in hospital. 16. John D., 27; died; duration of illness doubtful. 17. Thomas C., 30; severe, but not unduly prolonged. 18. Alfred G., 21; made good recovery. 19. Jane B., 32; had two distinct relapses, extending over 81 days. 20. Alfred B., 18; a very severe case; slight relapse; now in hospital 44 days; slowly recovering. 21. Sarah B., 27; prolonged fever, with relapse; now in, 40th day; not convalescent.

It is not proposed here to enter into the details of these cases, but only to make use of them in illustration of certain salient and indisputable points. All the patients were young and healthy, and four were children. In the twenty-one cases, as will be seen, there were as many as five deaths; there are six examples of relapse, two of them fatal; five (not relapsing) had very slow recovery, three of them being still in hospital, barely convalescent, after many weeks' illness. Only six of the twenty-one—or, excluding two children, in view of the special character of typhoid in early life—only four adults out of nineteen persons made a good and proper recovery, in the sense of being apyrexial and on the way to convalescence towards the end of the fourth week.

1. As regards the high rate of mortality, I do not propose to lay stress upon that point, or to argue as though five deaths in twenty-one cases were almost the same as twenty-four in 100. At the same time five fatal cases out of seventeen consecutive examples of enteric fever in adults (the children may be fairly excluded, inasmuch as children hardly ever die of typhoid fever), is a proportion which cannot fail to strike everyone who is familiar with the usual features of the disease. Extensive ulceration existed in the four cases examined after death, with perforation and peritonitis in two of them. In one, pneumonic consolidation was also found. Examination was not permitted in the fifth case.

2. Of the six examples of relapse, one of the two that were fatal advanced so near to recovery as to be up and about the ward. The relapse occurred on the fortieth day, and proved fatal in sixteen days. In another case (Jane B., under Dr. Allchin's care), the patient became unconscious, evacuations were passed into the bed, and she appeared to be actually dying. Recovering, however, from this first attack, she had two distinct repetitions of fever, each with fresh spots and renewed diarrhoea. The first relapse lasted seventeen and the second fourteen days. The two occurred respectively on the thirty-fifth and sixty-seventh days from the original attack. In a fourth case, that of Mary C., a child aged eight, the relapse was not of long duration, but the first attack was severe and protracted. In the two remaining cases (the last of the above list), admitted respectively on the 9th and 13th

of November, the fall of temperature at the end of the third week proved delusive as regards the term of the illness. Both are still in hospital at the time of writing (December 16th), and not yet convalescent. In the case of the girl, the temperature has for some time been subnormal, but she continues prostrate with the aspect and posture of typhoid, and thickly furred tongue.

3. Apart from relapse (although it is not always easy to separate the two classes, since a fall of temperature, longer or shorter, occurs almost in every case between the twentieth and twenty-fifth days), five cases were *tediously prolonged*. Three of these are still in hospital, and after more than two months of illness not yet convalescent. In respect of prolonged convalescence indeed, and in that respect only, the present epidemic resembles that of two years ago, when, however, cases of death or near danger were very rare.

4. In seven of the cases, some *intercurrent inflammation* either interrupted recovery or had a share in the fatal result. Three had bronchitis (one of whom died), two had pneumonic consolidation (one of whom died), one pleural effusion, and one cystitis.

5. With reference to the remaining point, the *insidious character of the attacks and the misleading nature of the earlier symptoms*, I can, of course, only speak of such examples as fell under my own observation; but I believe a like description applies to other cases as well. A brief account of three instances of the kind will serve to illustrate my meaning. Henry C. was admitted on the third day of fever, with temperature of 100 and pulse of 90. The abdomen was full, but not tense nor tender. The first week, both pulse and temperature gradually fell, and there was no action of the bowels. On the eighth and ninth days, when the pulse was below 80, he had two scanty motions. On the eleventh day he had very slight hæmorrhage—a few specks of blood only. There was but one motion of the bowels between this and the fourteenth day. Then the pulse rose, diarrhoea set in, and five days later the man died with perforation, symptoms of peritonitis having set in two days before.

In the second case, James A., 22, a strong labouring man, admitted on the sixth day of fever, the temperature just exceeded 103° on two days, but for the first ten days the pulse was barely over 90. From the ninth day to the eighteenth the temperature gradually fell, and the diarrhoea, which had been present during the second week, ceased. From the sixteenth to the twenty-first the temperature of each day reached 100, but the pulse was not accelerated, and on two days only was there any diarrhoea. On the twenty-first and twenty-second days the temperature fell gradually to 99, and the aspect and other signs seemed to indicate the ending of the fever. On the twenty-seventh day, however, after eating a piece of biscuit which had been smuggled in by his friends, the temperature rose to 102, and the patient complained of abdominal pains, but did not appear materially worse. The bowels continued confined from the twenty-eighth until the thirty-sixth day, when violent pain set in, accompanied by diarrhoea, the patient became collapsed, and died in a few hours of perforation.

By the side of this case, where the indications of ulceration were faint, the symptoms throughout of little urgency, yet the apparent recovery deceptive, I will place one of a different kind, but where the early signs were equally misleading, and such as would amply have justified an unfavourable prognosis.

Alfred B., aged 18, a labourer, was admitted on the ninth day of his fever. He had profuse diarrhoea, dry tongue, and several spots. The temperature was 104.8°; the pulse varying from 132 to 160. Up to the fourteenth day, the temperature ranged between 104° and 105°, daily; the diarrhoea continued beyond control, and the pulse was still 140 or more. The boy lay groaning and sleepless, and had delirium during the night. Nevertheless, on the twenty-first day (diarrhoea having ceased on the sixteenth, and the temperature descending therewith), the pulse had fallen to 102, and the face betokened those well known signs of coming out of fever, which, although not always lasting, are yet unmistakable. On the twenty-fifth day, the temperature became normal, and so continued for a week; the boy, although wasted almost to emaciation, expressing himself as well, and clamouring for food. Then, for a few days, with the long continuance of constipation and indications of loaded lower bowel, the temperature rose to 101°, and the patient complained of abdominal distress. With the relief of this condition, however (a part of the treatment of no small difficulty and delicacy in the circumstances), the boy resumed his progress to recovery; and now, on the forty-fourth day, although extremely weak and with a nightly rise of temperature, he is in that condition of hunger and contentment which marks the convalescence of enteric fever.

Had I been called upon to express a definite opinion, as to the final result in any of the three cases just quoted, at an early stage, I make no doubt that I should have been wrong in all.

Other cases might be quoted to the same end; perhaps I have not

chosen the best. Yet the general view of these twenty-one examples bears out, I would submit, what was said at the beginning. So far as my own experience goes, which covers twenty years' pretty constant hospital attendance, the typhoid fever of this season has been singularly anomalous and, so to speak, disappointing. It has been almost invariably prolonged and tedious, more than commonly fatal, and very sparing of symptoms to indicate the iliac ulceration, which is the main source of its danger. And it has been treacherous as well as obscure. Seeming recovery has been followed by a fatal repetition, the most approved and apparently benign form of the disease has ended suddenly in death, and sometimes, when the proper symptoms have been kept in check, some local inflammation, occurring in the course of the fever or as its sequel, has either prolonged the illness or contributed to its fatal termination.

During the present month—subsequently, that is, to the period to which the foregoing observations refer—three cases of enteric fever have been admitted; two are in their second week, and cannot therefore be counted. The third, a boy aged 18, was admitted on December 1st, under Dr. de Havilland Hall, on the twelfth day of his fever. The illness ran a mild course, the temperature never reaching 103°, the pulse remaining below 90, and the bowels remaining quiet (one action daily). The temperature, descending gradually, was normal on the twentieth day. On the twenty-third, it began to ascend; and now, on the twenty-seventh day, it is above 103°—higher, that is to say, than it had ever reached during the three weeks of the fever. If this example were added to the others, we should have seven relapses out of twenty-two cases, or seven out of twenty, excluding two young children.

With so unpromising a record of the past, it is gratifying to add that no fresh case of enteric fever has been admitted since December 2nd; and that, with the setting in of winter weather, the epidemic seems to be on the decline.

In concluding, I must express my obligations to my colleagues for this use of their material, as well as to Mr. Hebbert, our medical registrar, for the kind help he has given me in bringing the facts together.

ABSTRACTS OF CLINICAL LECTURES.

Delivered in the Queen's Hospital, Birmingham.

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SOME POINTS IN THE TREATMENT OF ACUTE RHEUMATISM.

SINCE the approximate perfection of surgical anaesthesia, the healing art has won no greater triumph than in the employment of the alkaline salicylates in pyrexial rheumatism. I say in pyrexial rheumatism, because I have not found the salicylates of any use in rheumatism with a normal bodily temperature. I think I know the fallacies which beset any therapeutic inference; and I make allowance for the special sources of error which adhere to therapeutic inferences respecting pyrexial rheumatism, and especially to such rheumatism in hospital patients; but, with a hospital experience reaching back some years, and with several years' experience as a house-physician in a large hospital, long before salicylates were thought of, I feel sure that the alkaline salicylates, and especially the salicylate of soda, have the power, in a larger degree than any other drug or combination of remedial measures whatsoever, of greatly abridging the course, and markedly mitigating the pain, of the simple forms of rheumatic fever. In making this affirmation, I compare the results of salicylates with four distinct and well-known therapeutic plans for dealing with rheumatic fever—namely, by free administration of bicarbonate of potash, by perchloride of iron, by blisters, and by rest in bed and nursing care, without drugs. The routine dosage I adopt in rheumatic fever is, to give fifteen grains of salicylate of soda, dissolved in one ounce of water, every three hours. As the patient's temperature falls, and the articular pains diminish, the frequency of the dose of salicylate may be lessened; but the remedy should be given, at least thrice daily, for at least a week after the temperature has remained normal and pains have gone. If you omit the drug too soon after defervescence and the removal of pain, the patient is very likely to suffer from a relapse. Relapses are frequent when the salicylate is given up too soon.

I have not observed that the salicylates have either prophylactic or remedial value in the cardiac complications of rheumatic fever. If such complications—endocarditis, myocarditis, or pericarditis, singly or variously combined—occur, they usually become manifest in the first week of pyrexia. For the ordinary endocarditis of rheumatic fever, I do not know that any drug is of direct service, excepting, perhaps, a little aconite, if the pulse be of disproportionate frequency. But I am

strongly of opinion, that the future of a patient, who has had acute endocarditis—and by his future, I mean the length of his life and the degree of his suffering from the remoter and almost inevitable effects of endocarditis—is very largely influenced by the way in which he has spent his convalescence from the illness with which such endocarditis at its onset was associated. Prolonged rest, rest in bed for several weeks, or even months, does infinite good after an attack of endocarditis. Such rest nurses the damaged heart; it keeps cardiac action and pulse-rate down, and so promotes the removal of inflammatory products from affected cardiac valves and orifices. The passage of such products into organised connective tissue is a deadly process, irremediably puckering valves and narrowing orifices, and inevitably leading, often very soon, to the fatal mechanical consequences of obstructed blood-flow through the heart. All practitioners, who have had opportunity of comparing hospital practice among the poor with private practice among patients of comfortable circumstances, must have noticed the striking relative tolerance of cardiac lesions by the well-to-do. Such tolerance depends on no single cause; but I believe it has a great part of its explanation in the consideration I have pointed out. The rich are longer in resuming their occupations, after a serious illness, than are the poor. For pericarditis, I have faith in fly-blisters. I advise you to apply, in the case of an adult patient, a blister (six inches square) over the heart, directly pericarditis is declared. I prefer the old-fashioned emplastrum cantharidis; its slow action, extending over a dozen hours or more, is an advantage. In every case of acute rheumatism, take care not to clothe the patient's bed too heavily; but bed him in blankets, without sheets, and freely swathe all tender parts with absorbent cotton-wool.

LARGE DOSES OF ARSENIC IN CHOREA.

This little girl, ten years old, about to be discharged, owes her recovery from chorea to the administration of arsenic. We had to give the remedy freely before the disorder gave way. The case was one of subacute general chorea, of moderate severity, occurring in a weakly, nervous girl. We began with five minims of Fowler's solution of arsenious acid, thrice daily, in an ounce of water. In three days, the dose was increased to ten minims; in three days more, to fifteen; in three days more, to twenty; and so on until she was taking thirty-five minims of the solution thrice daily. When this last dose was reached, the choreic movements, which before had been gradually subsiding, entirely ceased; and a little vomiting warned us that we had reached the first and most usual physiological action of our remedy. We then withdrew the drug for two days; after that time we gave it again, in fifteen-minim doses, for a few days more, when we gave it up altogether, and the child remained well. You have seen me treat many cases of chorea in this way with similar success. The dose of liquor arsenicalis in chorea, as laid down in text-books, is too small. Chorea is often an obstinate affection. The more chronic cases frequently pass from doctor to doctor, and go through long courses of medicaments, without benefit. Arsenic, freely and properly given, rarely fails. If a case of chorea come to you, and you learn that arsenic has been given and has failed, give it again, in large doses. You may cautiously increase the dose of liquor arsenicalis, far beyond the limits of the text-books, with the best results in chorea; in this way, you may usually cure cases which smaller doses of the remedy would not affect.

TREATMENT OF ECZEMA.

Do not neglect to learn the treatment of diseases of the skin, and especially of eczema—by far the commonest of such affections; and of which you can always find many examples in our out-patient work. By attention to a few well-established details of practice, eczema can generally be cured, and always greatly ameliorated. I want to impress upon you two points of practical moment. Eczema is often brought out and kept up by local irritation, and it is always an expression of a diathesis. We can often best treat eczema by not regarding it as a disorder of the skin. In failure to recognise, and treat successfully, the general constitutional condition with which the affection of the skin is associated, and which is its foundation, lies a frequent cause of failure to cure eczema. Eczema is mostly a local expression of one of several diatheses—the strumous, the gouty, and the nervous. Some local irritation usually determines and frequently keeps up an eczema, and is its ultimate cause; but the proneness to the local malady, its penultimate cause, the reason why the local irritation results in eczema and not in something else, is to be found in some general constitutional abnormality. In a case of eczema, before you prescribe drugs, always search for, and, finding, remove, causes of local irritation—such as dirt, lice, scratching, rubbing, the wearing of flannel next the skin, or exposure of the affected part to the irritating action of heat, cold, water, urine, discharges, bad soap, or any mechanical or chemical irritants, such as are met with in various occupations.