in women. There is often a history of previous acute infectious disease, which strongly suggests that the serositis is bacterial. Out of 14 cases, in 7 the peritoneum and pericardium and both pleurae were all affected. In the remaining 7 one or more of these serous membranes, but not all, were affected. Perihepatitis is always present, and perisplenitis is nearly always present. Probably in the great majority of cases this disease begins in the peritoneum and the other serous membranes are affected later, but there appears to be a small group of cases in which the pericardium is first affected and the other serous membranes are involved later. When the pericardium is first affected it is very likely that indurative mediastinitis will be present, the connective tissue around the pericardium being thickened, so that the lungs are bound in one mass to the pericardium; the patients usually waste; the disease is virtually never associated with cirrhosis of the liver; the right pleura is more often affected than the left, which may be due to the fact that perihepatitis occurs early. The kidneys are often granular. As far as I know, the prognosis is very bad, but cases may last years. The woman who forms the subject of this lecture, you will remember, survived nearly seventy tappings. There is a large amount of albumen in the ascitic fluid, which supports the suggestion I have made that the ascites is not due to pressure on the portal vein. The histology of the thickened membrane clearly shows that it is inflammatory; the exudate upon the surface of the serous membranes becomes organized. If you cut sections, you will see proliferation of the connective tissue of the capsules of the various organs and successive layers of fibrous tissue, the exudation having become organized. We know very little about the cause of this condition, but certainly a considerable number of the sufferers have chronic granular kidney, and it seems to bear some relation to specific fevers.

With regard to our case upon which I am lecturing, it was unfortunate that she died out of the hospital, and therefore that we had no *post-mortem* examination, but I brought her case forward because she certainly had chronic peritonitis with perihepatitis. We know that as the result of the tapping, and because we could feel the rounded liver. It may have been that she was an example of this disease as confined to the abdomen. But I would suggest to you that probably she was an example of genuine multiple serositis; for you will remember that she had fluid in both of her pleural cavities. You will notice that there is no boundary between cases of simple chronic peritonitis and those of multiple serositis, the difference depending merely upon the number of serous membranes affected, and it may well happen that a patient dies from simple chronic peritonitis, but if he had lived longer he would have become an example of multiple serositis.

The only thing which remains to be said is to try to find an explanation for the oedema of our patient's feet. If she had had associated pericardial trouble, it might have been easy to explain the oedema of the feet by backward pressure. But we had no evidence of that, nor had she albuminuria. So we suggested at the bedside, remembering the extreme degree of chronic peritonitis, that possibly the contraction of the thickened peritoneum compressed the vena cava and so led to oedema of the feet. But if it did so, the compression must have occurred below the renal veins, because there was no albuminuria.

With regard to the treatment of the condition, I am sorry to say we can do but little. Diuretics hardly seem to restrain the accumulation of the fluid, and as far as I know there is nothing which will do it. The only thing seems to be to remove the fluid frequently, as was done in this case. We never had to remove it from the pleural cavities; probably its withdrawal from the abdomen prevented a great accumulation in the chest.

REFERENCES.

[1] Nicholls, A. G., *Studies from the Royal Victorian Hospital, Montreal*, vol. i, No. 3, 1902. [2] Ramsbottom, A., *Ascites as a Prognostic Factor in Alcoholic Cirrhosis of the Liver and Simple Chronic Peritonitis* (Sherratt and Hughes, London and Manchester), 1906. [3] Taylor, Frederick, BRITISH MEDICAL JOURNAL, 1900, vol. ii, p. 1698. [4] Thompson, Campbell, *Trans Roy Med. and Chir. Soc.*, vol. lxxxiv. [5] White, W. Hale, (*a*) The Cause and Prognosis of Ascites due to Alcoholic Cirrhosis of the Liver, to Perihepatitis, and to Chronic Peritonitis, *Guy's Hosp. Rep.*, 1892; (*b*) On Perihepatitis, with an Analysis of Forty Cases, *Trans. Clin. Soc.*, vol. xxi, p. 219.

A PLEA FOR A NEGLECTED REMEDY.

By EUSTACE SMITH, M.D., F.R.C.P.,

SENIOR PHYSICIAN, EAST LONDON HOSPITAL FOR CHILDREN; CONSULTING PHYSICIAN, VICTORIA PARK HOSPITAL FOR DISEASES OF THE CHEST.

IN these days of progress, when "modern methods of treatment" are so much belauded, and the home of every registered practitioner is flooded with a ceaseless stream of pamphlets acclaiming the virtues of new synthetic drugs (samples enclosed), it may be useful to spare a thought to some of the old remedies which are fast slipping out of mind and are in great danger of being forgotten. Of the new drugs, if past experience is to be trusted as a guide, few are likely to prove of permanent value. In comparatively recent times how many of such remedies have been placed with more or less flourish upon the market, but only to be laid quickly aside as disappointing if not altogether useless? Few have outlived the test of adequate trial. After a short experience of such failures one is disposed to cling more and more firmly to remedies which have stood the test of time and whose value was once universally acknowledged. Of these some have been neglected owing to our change of view with regard to the management of disease and the complete disuse of the antiphlogistic method of treatment. Fevers and inflammatory or catarrhal conditions, which used to be treated indiscriminately by measures directed to the reducing of a supposed "plethora"—by which term was understood either a general hyperaemia or a local determination of blood—are now managed upon a very different plan, and bleeding, together with the free internal use of the potassio-tartrate of antimony, has been abandoned in favour of ammonia and other drugs of similar action. But because antimony in full doses produces profound discomfort and depression it does not follow that the drug, if given in more moderate and prudent quantity, is not a remedy of the utmost value. In catarrhal states of mucous membrane antimony has never been dislodged from its eminence by later substitutes.

In cases of bronchial catarrh and bronchitis its neglect is the more to be deplored because there is no other drug of approximate value which can be given in its place—at any rate with equal advantage. On this subject—the treatment of bronchitis—I find the most erroneous views (as I think them) prevailing amongst the younger generation of medical practitioners. A young house-physician will order a patient who is suffering from a severe pulmonary catarrh a mixture containing carbonate of ammonia and other stimulating expectorants as a matter of course and in total disregard of the stage of the derangement or the character of the symptoms. But in the management of a bronchial catarrh each class of remedy has its own time for serviceable action and is useless or worse than useless if given out of its due season. The whole treatment of this derangement consists in unloading the congested vessels and setting up free secretion as a first and indispensable step before any attempt to reduce the amount of expectoration can be made. To give ammonia, squill, parsgoric and other stimulating and antispasmodic drugs in the early stage of the catarrh is to make the cough harder and the chest tighter, and greatly to aggravate the discomfort of the patient, if not to produce worse ill-consequences. By such means I am convinced that what should have been a mild indisposition has often been aggravated into a serious illness by driving the catarrh further and further into the minuter tubes, and that in children a moderate bronchitis has not seldom been turned into a broncho-pneumonia. The use of these remedies should be reserved strictly for the later stages of the catarrh when the cough is perfectly loose from a free secretion of mucus. The earlier remedies have then finished their work, and the time has come for stimulants and astringents to take their place, and begin their task of bracing up the relaxed mucous membrane and guiding the complaint to a satisfactory issue. Antimony is not employed with any view of depressing the patient, and therefore it is advisable to prescribe it in small doses, frequently repeated, rather than in larger doses given at longer intervals. It not only acts more efficiently when used in this way, but its effect can be more easily noted, and the dose repeated more or less often according as it

may seem desirable. It is well to combine the drug with nitrate of potash, acetate of ammonia, spirits of nitrous ether, or such other things as have a diaphoretic action upon the skin, for all these exercise a similar influence upon the bronchial mucous membrane. The most convenient form is the vinum antimonialis, of which a dose of from 2 or 3 to 10 or 15 minims, according to the age and condition of the patient, may be given, combined as above, every hour or two hours as long as the symptoms are acute. Great severity in the attack is no bar to the use of the drug; indeed, the opposite is the case, for when the distress is great, the breathing difficult, the cough hacking and incessant, and the pulse small and feeble, the beneficial effects of the remedy are the most decided, and it will be noted that the lividity and discomfort abate, and the feeble pulse gets fuller and stronger as the secretion from the lungs gets more and more abundant and free. In these severe cases the remedy should be pushed with a prudent liberality, for peddling doses are not only useless but lose valuable time, while if any signs of depression occur they can be met with suitable alcoholic stimulation.

In the early stage of broncho-pneumonia in children, antimony is a remedy of undoubted value. It is most useful at the period when the consolidation is still in patches, and before large areas of lung have become implicated, giving rise to definite bronchial respiration and all the signs of wide consolidation. It is also at this early stage that the belladonna treatment is so valuable, and the two remedies may be combined, giving 10 or 15 minims of the antimonial wine with ¼ grain of the extract of belladonna every two or three hours until the pupils begin to dilate. In bad cases the belladonna may be pushed still further so as to induce a mild delirium. In broncho-pneumonia, as in bronchitis, antimony is useful only in the earlier period of the complaint, and should be discontinued directly obvious signs of lung consolidation have become established.

Another disease which is greatly benefited by the use of antimony is stridulous laryngitis. Dr. Cheyne used to speak of the remedy as the only medicine to be trusted when the complaint had become fully developed, and declared that it had been his sheet anchor for thirty years. To produce its full effect the remedy should be administered in frequent doses of 15 or 20 drops of the wine, so as to induce a slight feeling of nausea. In very bad cases it may be advisable to excite one effort of vomiting, but afterwards smaller doses should be prescribed, and repeated every hour or so until the acute symptoms have subsided. Hot fomentations to the throat add materially to the success of this treatment. If the child be old enough, the local application of a weak solution of the potassio-tartrate of antimony (gr. ¼ to the ounce of water) may be resorted to; and if the patient can be induced to inhale deeply as the solution is sprayed into his throat for a minute at a time, the violence of the spasm is quickly reduced. Unfortunately this expedient is unfitted for very young children, whose co-operation can be rarely depended upon. Instead of the solution of potassio-tartrate of antimony, ipecacuanha wine may be used diluted with an equal proportion of water, but this is more unpleasant than the antimonial solution, although equally serviceable.

There is another use for the antimonial salt which must not be forgotten. It is a recognized fact that all nauseating medicines when given in minute doses lose their irritating properties and become gastric sedatives. Good examples of this law are seen in the case of ipecacuanha and zinc sulphate. Ipecacuanha wine given in doses of 1 minim in a spoonful of water is now a familiar remedy in cases of vomiting; and sulphate of zinc in doses of $\frac{1}{12}$ to $\frac{1}{6}$ grain, taken before food in a spoonful of some bitter infusion, is one of the most trustworthy and satisfactory of stomachics. In the same way, antimony prescribed in doses of 1 or 2 minims of the wine is a useful addition to the prescription in cases of gastric derangement and contributes materially to its curative value. An old-fashioned remedy for gastric pain occurring after meals contains 1½ grains of potassic-tartrate of antimony, with 1 oz. of magnesia, 6 drachms of bicarbonate of soda, and 5 drachms of tartaric acid; of this one teaspoonful is ordered to be taken in half a tumbler of water when the pain begins. In cases of flatulent dyspepsia accompanied by severe pain after all food I have found this treatment not only to afford temporary relief, but to have a decidedly curative influence upon the derangement.

Again, it must not be forgotten that antimony is not without value as a hepatic stimulant. It is to this quality that it owes its inclusion in the old pharmacopoeia preparation known as "Plummer's pill," in combination with calomel and guaiacum. Moreover, by its influence in promoting secretion from the intestinal mucous membrane, the drug is a useful addition to the aperient in cases of chronic constipation where the stools are exceptionally dry and hard. A small quantity of the potassio-tartrate ($\frac{1}{25}$ grain to $\frac{1}{20}$ grain) may be combined with podophyllin ($\frac{1}{6}$ grain), compound extract of colocynth ($\frac{1}{2}$ grain), extract of belladonna ($\frac{1}{6}$ grain), and extract of nux vomica ($\frac{1}{4}$ grain) in a pill to be taken each evening before dinner. In its value as a gastric and general tonic antimony may be compared to another salt—the perchloride of mercury. The latter, if given perseveringly in small doses, is a remedy highly to be prized even in cases which are connected in no way with the constitutional disease for which it is generally acknowledged to be a specific. In certain derangements of the lower bowel the usefulness of perchloride of mercury is well known; but it is not equally well known that if ordered in doses of 10 or 15 minims in combination with half that quantity of the tincture of perchloride of iron, and taken well diluted with water three times a day after food, the remedy is of extreme value in chronic tuberculous disease of bone, and if persevered with for a few months will usually effect a decided change for the better. In using this method, no fear need be entertained of producing salivation or any of the untoward consequences of the overuse of the drug.

In small doses antimony is of value also for its action in inflammatory conditions of the skin. In eczema, whether acute or chronic, the drug is one of the most satisfactory of internal remedies if continued perseveringly. I have found 5 drops of the wine taken as an adult dose in a teaspoonful of water after each meal to produce speedy improvement in cases of long standing when arsenic and other remedies had been prescribed without any beneficial result. This quality of the drug is well recognized by dermatologists; indeed, so far as I can gather, in these days the remedy is practically confined to the treatment of skin diseases, at any rate amongst the newer school of practitioners.

In old times antimony was prescribed for very many other complaints, but in all of these the drug has been displaced by other and equally successful remedies. I do not advocate a return to antimony in such cases as these, where later methods of treatment give satisfactory results, but only regret that in cases for which it is especially serviceable the drug should be made use of so rarely. No doubt it is still retained in stock mixtures of the various hospital pharmacopoeias, and is therefore in common use in those institutions, but it is only because it happens to form a part of the prescription, and not on account of any wish to make use of this particular drug. Outside a hospital the remedy is practically ignored, and of late years I have rarely known it to be prescribed by practitioners of the modern school upon their own initiative. The prejudice against it which nowadays appears to exist is derived from the abuse and not the use of the drug. With our present views we do not, as formerly, prescribe the salts of antimony with any desire to produce a profound sedative effect upon the vascular and muscular systems, so that even in pushing the remedy we are careful to limit our efforts to obtaining free secretion from the mucous surfaces and the skin. For this purpose, however, antimony remains pre-eminent, but it should always be prescribed in small doses given frequently, for it is only by this means that its full effect can be obtained without any danger of lowering the patient and giving rise to unwelcome signs of depression.

A Society called the Anglo-American Society of Vienna has recently been formed, to make known in England and the United States the artistic and scientific resources of Vienna, and to facilitate visits of English and American students to Vienna. H.H. Princess M. A. Lubomirska is the President of the Society, Dr. G. de Griez, Honorary Secretary, and Mr. O. S. Phillpotts (English Vice-Consul), Treasurer. The head quarters are at the Imperial Hotel, and communications may be addressed to M. Charles Cahier, Honorary Manager, there.