

portion with higher pitched note throughout. Breathing somewhat tubular, unable to find rales either posteriorly or anteriorly.

Diagnosis-Fibroid Lung. Cavity previously mentioned as located on left side near sternum in third interspace replaced by slight hyperresonance.

Case 2. Lydia W. Age 18 years. Epileptic who had pulmonary tuberculosis and had previously been in fair health, was sent to quarantine hospital on June 4th with slight prodromal symptoms. Eruption was in beginning vesicular stage and evenly distributed over body involving palms of hands and soles of feet. Patient was suffering marked malaise. Evening Temp. was 100. Second day after admission morning Temp. 99 and evening 98.6, patient feeling more comfortable.

There were old tubercular lesions in the apices of both lungs but for eight days temperature remained practically normal.

Eruption became generally pustular on the 4th day crusts began to form 6th day and on the 8th crusts were all over body and eruption was drying rapidly. On 10th day crusts were off to great extent. Patient however scratched thus delaying desquamation. Temperature rose to 101 in evening, she became restless and evidently suffered acute pain and marked malaise. Evening temperature ranged from 101 to 103 for six days. Muscular twitching around mouth and this increased in severity. Breathing became rapid and labored and restricted on left side. Dullness over upper lobe of this side and became more marked and extended to 4th rib nipple line.

Abdomen became slightly tender and tympanitic. Stools foul smelling and light colored. Unable to find evidences of Blight's disease, urine remaining clear and light.

On the 16th day had a convulsion of petit mal type. Pulmonary symptoms became more marked and on 19th day desquamation was complete and patient could have been released from quarantine had it not been for tubercular symptoms. Morning Temp. 102.6, evening 104. On the 20th day morning Temp. 104.2, died at 3.15 P.M. Diagnosis, acute exacerbation of chronic tuberculosis.

In both cases the tubercular process was made more acute by the small-pox. The 2nd case however had epileptic seizures at last and could not be stimulated as strongly as the first and according was not able to survive.

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EDITORIAL.

CONTAGIOUS DISEASES IN INSTITUTION FIFE

When people are housed in large numbers, the question of protection from contagious diseases deserves serious consideration. The condition of intimate association favors the rapid spread of these diseases, while on the other hand the control of the population is so complete that the medical staff have an advantage in handling an epidemic over the health authorities in charge of an ordinary outbreak.

Most well regulated institutions require a certificate of recent vaccination in each case admitted, and make very careful inquiries into the possibility of exposure to other contagious or infectious diseases. Of course, exposure to cases unrecognized while enroute to the institution cannot be guarded against, but by the usual precautions indicated above, and the additional one of thorough disinfection of all clothing brought with each new arrival and the requirements of a thorough soap and water bath, the danger of in-

roducing disease from this source is reduced to the minimum. Employees, over whom the administration does not have such complete control, are the usual media for the introduction of these diseases, and even if the management of an institution should require as a condition of employment that the applicant and his clothing should undergo the same cleansing processes required of inmates, the fact of more or less frequent visitation with relatives and friends outside, involves the constant possibility of introducing bacteria.

Of all infectious diseases the spread of measles is the most difficult to completely control because of its extreme contagiousness at the first onset of the disease. Among the feeble-minded it is noticeable that the Mongolian type are especially susceptible to severe attacks of this disease. In fact, measles seems to vary in severity according to the individual, and one is never safe in predicting a light epidemic because a few of the earlier cases are not very sick.

Small-pox, thanks to vaccination, can usually be kept out. The prevalence of this disease at the close of the Spanish American war and the existence at the same time quite universally of chicken-pox, presented an unusual danger. The article by Dr. Huxley in another part of this issue illustrates an epidemic at this time, which presented some very interesting features. First, the fact of accurate diagnosis. There had been quite a number of cases of chicken-pox all of which were carefully isolated with reference especially to the possibility of mistaken diagnosis, but in no case was there reason to change the same. It is, therefore, worthy of note that a case should have been recognized at once as small-pox in which the subsequent history justified this diagnosis as well. Others followed, the histories of all of which are given in the article referred to.

The second noticeable fact is that the first four cases of small-pox were mentally low grade males that we had decided not to vaccinate because of the danger of infection, from it being practically impossible to control and protect the vaccinated arms on idiotic and low grade persons.

The next point I wish to notice was, evident infection of a few cases by the action of the wind, which blew almost continually for a week or more from the direction of the building used for the care of these cases, toward the main building. Children became affected in the wing of the main building nearest the contagious hospital, although the latter was situated about five hundred feet distant.

The thoroughness of which the process of isolation and disinfection were conducted are worthy of attention as being, in the opinion of the writer, almost ideal. Imagine a building containing about two hundred custodial boys from which a case of small-pox has been taken. These boys and their care-takers must be kept entirely isolated from the population of all other buildings on the ground as well as from outside residents. They must have their three meals a day, their clothing and bedding must be laundered at regular intervals and in case of a large percentage of the inmates it must be done daily. The delivery of food and supplies to this building must be done without any individual contact, for safety lies only in the assumption

that every person and article in the building as well as the interior of the building, is a source of infection. Likewise refuse taken from the kitchens must be buried or disinfected by final boiling. The delivery man in charge of the laundry, must take to the infected building a disinfected bag, into which is placed the bag at the building containing the infected clothing and bedding, the delivery man himself wearing a gown which had been saturated with antiseptic solution to neutralize any material conveyed through this method of handling infected material.

Then again after a sufficient time had elapsed, without the development of new cases to justify disinfection and opening of the building, the physician in charge meets a proposition requiring heroic action. The clothing and bedding of the two hundred inmates and all their care-takers must be thoroughly disinfected. Every individual, including inmates and care-takers, must pass through an antiseptic bath which must be so thorough as to include the hair and the scalp. Every article of furniture, clothing and bedding must be thoroughly and completely disinfected and every wall and floor surface as well. The furniture, bedding and wall surface can be treated by fumigation, clothing and bedding by fumigation and boiling. This, however, must all be done with the population left in the building. To do this one story of the two story building was vacated by the population and thoroughly fumigated. Then the inmates were given their bath and transferred to that story leaving every removable article behind, after which the vacated story was given the same treatment. As during all this time this population had to be fed, some idea of the number of points of possible conveyance of contagion that had to be watched, can be imagined and it readily can be understood why the medical officer in charge had virtually no sleep or rest for thirty-six hours. It is needless to add that following this through work there were no more cases of small-pox.

Perhaps the most common of the major diseases is diphtheria. In fact, the bacteriologists have shown us that bacilli of diphtheria exist in a good percentage of noses and throats constantly, particularly among school children, whether in or out of public institutions, and this fact would seem to explain the impossibility of tracing the source of this disease in so many cases. This fact also makes it rather difficult to determine with precision how long cases with so-called infected throats should remain isolated. The presence of these bacilli alone or without clinical symptoms, does not seem to be sufficient justification for isolation, and their continued presence after clinical symptoms have disappeared may have no special significance. The use of antitoxin has shorn this disease of its former terrors, but it is nevertheless, important to properly diagnose the disease promptly in order to give the treatment in time. It is the custom in the institution with which the writer is connected, when a case develops with clinical symptoms suggestive of diphtheria, to have a culture made immediately, and if the microscope confirms the diagnosis, to have swabs taken from all throats and noses of the persons in the class from which the patient was taken and immediately isolate all that are positive, and thoroughly fumigate the departments,

clothing and bedding where these patients live. This simplifies the handling of these cases and makes it unnecessary to quarantine whole buildings. The cases removed are, of course, kept in isolation until the microscope justifies their discharge. Where the institution is provided with a laboratory equipped with incubator and microscope, and a trained bacteriologist is connected with the staff, the handling of diphtheria even in the large institution population, especially if the latter is divided into a goodly number of separate groups in different buildings, is comparatively an easy matter. It is well, however, to have the culture examination made by the health authorities at the same time, not only as a verification of the laboratory work in the institution, but to insure confidence on the part of the public.

It is gratifying to note the very general activity of the medical profession assisted by the leaders from all professions, in educating public sentiment concerning the care and treatment of tuberculosis. Of this and other infectious diseases in institutions we may have more to say later.

NOTES AND ABSTRACTS

IN the Journal for Sept. 1902, page 30, was printed an abstract of an article by M. Bra on the presence of a parasite in the blood of epileptics. Recently he has reviewed the literature and brought the subject down to date. *His article acted as a stimulus for a number of observations. M. Besta examined 125 fresh specimens and found no organism in any of them. In 375 cultures he twice found staphylococci, once coli, once tetrag and once an undetermined spirillum. He thinks that the result of Bra and Chausse are due to auto-infection and errors in technique.

Lannois and Lesieur examined the blood of epileptics during the attacks and their results were wholly negative both by cultural methods and on direct examination.

Ghiliarowsky, of Moscow, examined the blood of five epileptics both during the attacks, and in the interval, he made his examinations by means of fresh and stained specimens and by cultural methods. In five examinations he found a micro-organism corresponding to that described by Bra, in some cases getting pure cultures. His inoculation experiments were negative. He inoculated under the skin and not in the blood stream. On examining the blood of patients during and between their periods of maniacal excitement he finds a diplococcus exactly analogous to the one of epileptics, as shown by Bra, so he concludes that the micrococcus of Bra is the micrococcus agilis, and has nothing to do with the pathogenesis of epilepsy.

Tirelli and Brossa have examined a number of cases of epilepsy and have found some bodies similar to the ones Bra has described but from the difficulty in staining and of making cultures they have considered them as

*Recherches microbiologiques sur l'Epilepsie. Arch. de Neurol. Dec. '05. Ricerche batteriologiche nel sangue degli epilettici. Rev. sperius. di freniatria 1902. pg. 307. Examen bacteriologique du sang des epileptiques. Soc. Medic. Des Hospitaux de Lyons '03, Nov. 3.

fragments of the morphologic bodies of the blood.

The objections of his critics, M. Bra finds, are based upon three principal points, the rareness of positive findings, the difficulty of staining, and the difficulty of getting cultures.

That the positive findings on blood examinations have been few, the author admits. This he thinks is due in part to faulty technique and again, many preparations are necessary before one is successful. Also one will fail if the examination is made too long a time after the attack. Bromides, he finds, do not produce negative findings.

That the organisms are stained with difficulty by the simple methylene blue stains is true, but they are stained easily by carbol-thionin.

That it is difficult to make cultures is true of all blood organisms. The difficulty here he thinks is due to coagulation, so in making cultures he defibrinates the blood and sows in neutral or alkaline bouillon. The growth appears as a greyish tint in the bouillon which falls to the bottom of the tube and appears as a fine greyish deposit.

In the inoculation experiments the authors have failed since they used too small quantities, 20-30 cc. often being insufficient. The virulence of the cultures varies considerably. Some of them in doses of 10 cc. will kill in 48 hours, with others the rabbits live from eight to ten months. Autopsy shows atrophy of spleen and gall bladder, and the blood of the heart shows pure cultures of the neurococcus. Vaso-motor disturbances are noted after injection of cultures. This shows itself as an ischemia of the ear. This is soon followed by a dilatation of the vessels, then again by an ischemia, etc., the changes taking place rapidly.

Contrary to his earlier conclusions the author finds that serum diagnosis is not yet practicable since normal serum will produce an agglutination.

BOOK NOTICES.

LA CLASSIFICATION DES ENFANTS ANORMAUX. DR. O. DECROLY. GAND. 1905.

The author reviews somewhat at length the various attempts that have been made to classify defectives. While realizing the difficulties of the problem he offers the following:

I. Irregulars due to intrinsic causes.

II. Irregulars due to extrinsic causes (family and social surroundings.)

In the first class he distinguishes (a) in which the irregularity or defects lies in the vegetative functions, (b) those in which the irregularity or defect lies in the functions of relation (motor, sensory, affective and mental defects).

He wishes to make his classes large enough to include all children who for want of special training would become a charge on or a danger to society.

Those in whom the irregularity exists in the vegetative functions he divides into (a) those who have physical deformities and anomalies independent of the neuro-muscular system (deformities, monstrosities, etc.) (b) those who have disturbances of general nutrition and chronic diseases of the organs of