

sucked and after that a little iced soda-water and milk. Beef-tea or bread, or very light foods, are fatal to the successful administration of ipecacuanha; and to this cause a great many of the failures of ipecacuanha are doubtless to be attributed. On the second day the ipecacuanha can be reduced in quantity and supplemented by salicylate of bismuth, quinine, naphthol and opium. Milk should still form the staple article of diet. Later on farinaceous foods and soups may be carefully given, but a return to solid meat should be deferred as long as possible. Mr. Chowdhovry remarks "that the large doses of ipecacuanha, which have been found to be of great use in treating the dysentery in India, are often inadmissible by reason of the nausea thereby invoked preventing the patient from taking a sufficient amount of nourishment." Considering that the success of the treatment by large doses of ipecacuanha depends upon the condition of the patient in not taking any nourishment during the period of its administration, the failure in Mr. Chowdhovry's cases was evidently due to the fact that his patients were trying to take a "sufficient amount of nourishment," thereby actually causing nausea and preventing a cure. There are cases where ipecacuanha fails when administered by the mouth which may be very successfully dealt with by ipecacuanha and opium enemata.—Arthur H. Hart, M.B., etc., in *Lancet*.

A SUMMARY OF WHAT CAN BE ACCOMPLISHED IN THE TREATMENT OF CHRONIC BRIGHT'S DISEASE.

Before considering what may be hoped for or accomplished in the treatment of chronic Bright's disease, it is indispensable to state with precision what pathological conditions are to be considered as coming under the name of Bright's disease, or Bright's diseases. The cases described by Bright himself were characterized by œdema or dropsy, albuminous urine, uræmic symptoms, and extensive renal changes. Yet perhaps even the greater part of the cases which are loosely called "Bright's disease," present none of these conditions except that of mild albuminuria. That physiological or normal albuminuria exists, I do not believe. I think the thorough consideration and argument presented by Lecorché and Salamon upon this vexed question, show that it does not, and in the edition recently published of my own work on Bright's disease, I have devoted considerable space to this important subject. Thus far, none of my arguments have been refuted.

For the purposes of this paper I shall exclude the cases of simple, mild, chronic albuminuria, such, for instance, in which the urine does not

contain more than three centigrammes (about one-thirtieth of one per cent.) to the litre, which are unaccompanied by renal epithelia or casts, where there is no diminution in the amount of solids excreted, the functions of the kidneys are not deranged, and the general health does not seem to be impaired. And such cases are extremely common. I desire to state what has been and what may be the result of treatment in those cases in which organic changes in the kidney have brought about more or less grave disturbances of the health.

In advanced cirrhosis, where the interstitial tissue is contracted, and the cortex retracted and hardened, so many of the tubules must, of necessity, be obliterated or narrowed, that there would be a great loss or destruction of their investiture of epithelia, and there would not be left enough of these to enable the kidney to perform its formative functions, namely, the formation from the blood of the capillaries which surround the tubules (and often many of the capillaries are inflamed and sclerosed) of the solids which are excreted in the urine. The result of these conditions would be the excretion of the aqueous principles of the urine, containing but little solid matter in solution, and the retention in the blood of elements, which, perhaps, by their decomposition, contribute to the poisoning of the system and the irritation of the nervous centres, and, finally, the dire catalogue of the symptoms met with in advanced cirrhosis. In such cases we can ordinarily hope to accomplish nothing more than to palliate symptoms, and perhaps prolong life. Recovery or a cure is not to be looked for.

Likewise, where the kidneys have undergone considerable fatty change; in the amyloid kidney and in the large white kidney; where there is a daily loss of considerable quantities of albumin, the tubules being choked by swelled epithelia or filled with casts; where the casts from the broad tubules predominate; where the glomeruli are inflamed and incapable of separating the aqueous principles, and the urinary secretion is diminished; and where these changes are fixed and chronic, little, perhaps nothing, is to be expected in the way of a cure.

Nevertheless, between the numerous cases of mild chronic albuminuria and those of advanced cirrhosis and chronic parenchymatous nephritis, there exist many, even severe, forms of nephritis in which the structural changes are marked, and even chronic, and so great as even to produce grave conditions of health and endanger life (I do not here allude to acute nephritis), where much, perhaps everything, can be hoped for, and even expected, from well-directed theapeutics. In these cases we are not confronted by a condition of abject helplessness, but may address ourselves to the work of relief strengthened by a certain sense of power.