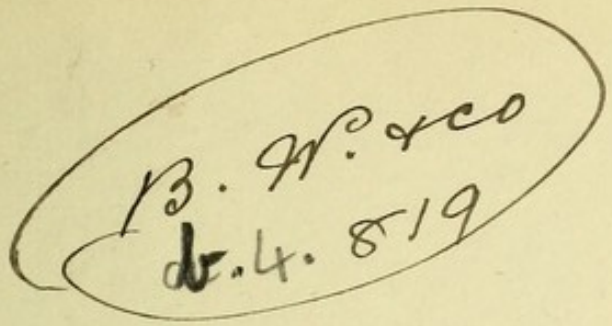
A practical treatise on diphtheria and its successful treatment / by Brownlow R. Martin.

DIPHTHERIA

AND ITS TREATMENT

MARTIN



A PRACTICAL TREATISE

ON

DIPHTHERIA AND ITS SUCCESSFUL TREATMENT.

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DIPHTHERIA

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ITS SUCCESSFUL TREATMENT.

BY

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1894.

Dedicated

TO

HIS OLD FRIEND AND FORMER TUTOR,

WILLIAM IRELAND WHEELER,

M D. AND M.CH. DUBLIN UNIVERSITY;

FELLOW AND PAST PRESIDENT R.C.S., IRELAND;

VISITING SURGEON TO THE CITY OF DUBLIN HOSPITAL,

ETC., ETC.

PREFACE.

In the face of the numerous writings of distinguished authorities on the subject of diphtheria, it is an invidious undertaking to try and dilate any further thereon; still, having given years of study and attention to this disease, and having been urged by friends, both professional and otherwise, to make the result of my researches known, I feel it is my duty to comply with the request.

I am further prompted to do so from the fact that most of the works on the subject are from the pens of noteworthy scientists (to whom the whole world, as well as the physician, owe a debt of gratitude), and represent rather the discoveries made in the laboratory; therefore, an article written by a *practitioner*, as the embodiment of his ideas thereon, may bring to the minds of the medical fraternity the details of everyday experience.

I am well aware that I have failed in many points to carry out an ideal work, and that having in several places struck out what may be called a new line for myself, I may possibly have been led by enthusiasm into what may prove erroneous ideas; still, I think a basis will be found for them, and in a disease not yet *fully* understood, room may be found for speculation where sufficient grounds can be shown therefor.

It may be thought that in these pages a spirit of egotism has been exhibited by the author; let the readers be assured that nothing is further from his mind. The personal pronoun has been used simply for the sake of brevity, the work itself having been undertaken with a deep sense of humility and a complete consciousness of the position he holds as a very small unit in a most noble profession.

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DIPHTHERIA AND ITS SUCCESSFUL TREATMENT.

THE number of victims claimed annually by diphtheria entitles every member of the medical profession to express his views on this malady and to do what he can to lessen the mortality therefrom, and in this way take his share in relieving suffering humanity.

The study of diphtheria has been for many years an object of special interest to me, and having discovered a method of treatment which has met with remarkable success, a success far surpassing my most ardent expectation, I desire to lay the subject before my *confrères* in a short treatise, fervently hoping that some advantage may be derived from a perusal thereof.

Diphtheria has been described by many

authors under different titles, but it was not until the year 1826 that it was first pointed out as a distinctive disease by Bretonneau, under the name Diphtheria (from διφθέρα, a skin). Since that time there have been many epidemics of it, chiefly in Paris and Boulogne, and it is supposed that Washington and the Empress Josephine, besides many other notable people, succumbed to this affection.

Pathology. Various theories have been held as to the pathology of the disease. Some authors have thought that it is a poison disease acting primarily on the whole system, the exudation being only a local manifestation, while others—among them Trousseau—that it is an infection of the patient by the absorption of the poisonous material of the false membrane. It is not my intention in these pages to discuss the conflicting opinions of many noteworthy scientific scholars, contenting myself with giving a *résumé* of some of those held by them; it being my sole desire to attempt to give my readers the result of 'practical' experience derived from years of close attention and careful observation.

Author's definition. I shall begin by defining diphtheria, as it presents itself to my mind, as a zymotic disease, that is to say, an epidemic or endemic affection,

due to some contagious poison, and characterized by both general and local symptoms, of which the general symptoms are those connected with all toxæmic affections, the local one being the formation of false membrane *primarily* in the throat; it being my firm conviction that when it occurs elsewhere it is either by continuity, or by metastasis, or by secondary toxæmia; and I found this belief on the fact that it is possible, as I hope to prove conclusively later on, to abort the disease or cut it short, if firmly grappled in time.

Etiology.

Numerous, and in many instances far-fetched, causes have been assigned for the disease, some of which I shall enumerate: the fungi which spring from damp soil, sewage poison, diseased potatoes, impure water, heredity, age, predisposition, animal and vegetable refuse, milk from diphtheritic cows, and it has been supposed to spring from cats, pigeons and fowls.

Of these theories the majority have been disproved. Of age it may be said that it more frequently occurs during childhood and youth. With regard to milk, cases have been traced to farms on which the cows were suffering from febrile affections, and it may be undoubtedly looked on as a vehicle for conveying the poison. Heredity may be a predisposing cause. Of the

others little need be said. In later years it has been traced beyond the power of question to a micro-organism, and that described by Professor Löeffler and Klebs is now recognised as the diphtheria bacillus.

Symptomatology.

As I have stated in my definition, the symptoms are both general and local. The general are malaise, increased temperature, *slight* sore throat, and enlargement of the submaxillary glands, asthenia, and in more severe cases, rigors, vomiting, and signs of collapse. Diphtheria always is of an asthenic type, and in some cases death has ensued from this cause alone (fatal asthenia), the system being, so to speak, knocked down at once by it. Another prominent symptom generally present is albuminuria, which seems probably to be due to physical degeneration, as well as internal congestion. The late Dr. Cormack (Quain's 'Dictionary of Medicine') attributes the presence of albuminuria to (1) Rapid waste of tissue and altered state of the blood. (2) Want of assimilation of the food. (3) Obstruction of the air-passages, causing congestion. The local symptom is the formation of false membrane, of

Diagnosis.

which I shall speak more fully later on.

The affections with which diphtheria may be confounded are croup, scarlatina, follicular

pharyngitis, tonsillitis, putrid sore-throat, and aphthæ.

Diphtheria is distinguished from croup in that in the latter the affection commences in the larynx, in the former it begins in the throat and pharynx.

From scarlatina, by the eruption and strawberry tongue of the latter. Dr. Booker gives a very clear description of the distinction between them, which it would be difficult to improve upon. He says: 'The secretion of diphtheria is white, thick, tough, and strips off in shreds; suppuration is exceptional, there is no ulceration, and it extends on the surface by continuity, preferably to the air-passages. That of scarlatina is yellow, cannot strip off; ulceration generally takes place, suppuration frequently, and it spreads to the ear rather than the larynx.'

From follicular tonsillitis and pharyngitis by the consistency of the secretion: in both of the latter it is white and flaky, and can easily be brushed off. In diphtheria it is fawn-coloured and adherent, and if detached, bloody and fetid sanies exudes.

From the gangrenous eschars of putrid sore-throat: in the latter there is deep and extensive sloughing, and the patient, for the most

part, dies of exhaustion. In diphtheria there is no sloughing, but something added, and the sufferer dies of asphyxia.

From aphthæ : the latter begins in the mouth, and seldom occurs in adults ; besides, the constitutional symptoms are far less severe than in diphtheria.

Post-mortem appearances.

The chief post-mortem appearances found in diphtheria are engorgement of the submaxillary glands ; a granular superficial infiltration of the mucous membrane, the cellular tissue being loaded with sanious pus ; a congested state of the internal organs with transudations into the serous membranes. The characteristic pellicle which constitutes the disease may be found in the pharynx, larynx, and trachea, nostrils and inner ear, and, moreover, on remote parts of the intestines.

Physical appearance of the membrane.

The physical appearance of the membrane is aplastic (cacoplastic, Dr. Cormack). Under the microscope it is fibro-laminated, made up of corpuscles, epithelial cells, and layers of fibrinous net-work, without organization or development ; of a dirty yellow or ash-gray colour.

Complications.

The complications that have occurred during the progress of a case of diphtheria are scarlatina, albuminuria, bronchitis, pneumonia, puer-

peral and typhoid fevers, urinary and perineal diphtheria, erythema, croup, tubercle, etc. It is hardly necessary to say that any of these add seriously to the danger which already exists. The author has seen scarlatina both preceding and succeeding to diphtheria, and intimately blended therewith. Albuminuria is an almost constant concomitant, so constant that it has come to be regarded as a symptom, but does not, unless scarlatina is also present, cause any permanent mischief. Pneumonia is a very serious complication, and will be found either of a low typhoid type or else hypostatic. It is not necessary to enter into details about the other complications mentioned.

Sequelæ.

The sequelæ of cases of diphtheria are numerous, the chief being long-continued debility and paralysis, which may be either local or general, it may only attack the palate and regions thereabout, affecting the powers of speech and deglutition, or it may give rise to general paralysis of the whole body. Other sequelæ that have been met with are heart-disease, angina pectoris, emboli, syncope, encephalitis, blindness, etc.

Treatment.

It would be a work of supererogation to mention one quarter of the number of the remedies that have found favour in the eyes

of various physicians. I shall merely allude briefly to a few which seem worthy of most merit. First, and in the front rank, stands tincture of the perchloride of iron, either alone or with chlorate of potassium. For general treatment this seems to be admitted on all hands to be the remedy *par excellence*. In the hands of some practitioners benefit has accrued from carbolic acid. Other remedial drugs are: permanganate of potassium, boracic acid, salicylic acid, sulpho-carbolates, biniodide of mercury, pilocarpine, oil of eucalyptus, resorcin, chloride of ammonium, ice, sulphites. Dr. Radcliffe recommends sulpho-carbolate of sodium in doses of from three to five grains. Dr. Seibert has invented a very ingenious instrument with which he injects the affected part with chlorine water. Professor Löeffler recommends corrosive sublimate, 1 in 10,000; cyanide of mercury, 1 in 8,000; chlorine water, 1 in 1,000; thymol, 1 in 500; alcohol, 20 per cent., etc.

It is far from my intention to criticise or find fault with any of the treatments advocated by experienced physicians, but I claim for my own (which consists of insufflations, frequent and free, of sulphite of magnesium) the following merits: its simplicity, efficacy, freedom

from pain or danger; the fact that, while being a solvent of the membrane, it is also a bacteriocide; and, being in the form of a very fine and sparingly soluble powder, it not only acts on the fauces and pharynx, but it also penetrates into the larynx and air-tubes, and may succeed where other remedies fail.

Having now briefly scanned some of the literature on the subject, I will endeavour to give my own views on the 'practical' side of the question, and even at the risk of being considered prolix, it is my intention to enter into the matter as minutely as I possibly can.

Let me trace the course of a typical case of benignant diphtheria, and although, so far as I can find out, I am the first to do so, I am of opinion that without the slightest stretch of imagination, it would be justifiable to divide it into five distinct stages, viz.: 1. The stage of incubation. 2. That prior to exudation. 3. That of exudation. 4. The formation of false membrane. 5. Convalescence or the reverse. In the first stage we find the usual febrile symptoms: temperature ranging up to 102° Fahr., headache, pains in the limbs, and general malaise. These not subsiding, and no exanthem or other fever appearing, upon examination of the throat an appearance externally and internally will be

found which to me is characteristic. Externally the submaxillary glands are enlarged, and have generally a doughy or œdematous feel to the touch. Internally, the tonsils, the pharynx, or the soft palate, severally, or all of them, are of a dusky red hue with a *granular* surface. No exudation is yet to be seen, but a keen observer will suspect, if he is not absolutely able to pronounce, what the disease is. This is what I see fit to call the second stage. The third stage rapidly succeeds. Now will be found the exudation gradually welling up between these granulations. The late Dr. Ranking, senior physician to Norwich Hospital, in his lecture, delivered in the year 1859, says: 'The uvula and tonsils are coated with a fawn-coloured fetid membranous deposit. Below this the mucous membrane is deep red with *papular elevations*' (these are the granulations I mention, but I consider they can be seen before the exudation takes place). This exudation is of a yellowish coloured aplastic lymph. As the disease advances, this exudation coalescing into a patch or patches of false membrane constitutes the fourth stage. In the next stage, if unchecked, the membrane extends to the larynx and bronchi, but this seldom happens in the mild form with the use

of suitable remedies, and convalescence, as a rule, may be looked for.

Now trace the severer form. In it all the symptoms are aggravated. It is generally ushered in by a rigor—high fever, 103°-105° Fahr., and vomiting; then, in the second stage, will be found slight pain in swallowing, the fauces seem engorged and tumefied, and there is considerable prostration. In the third stage abundant fetid lymph exudes from numerous small spots, always calling to my mind what is seen in the commencement of a carbuncle. The fourth stage supervenes, and we find the fauces, soft palate, and pharynx covered with a false membrane, which possibly invades the posterior nares, soon extending to the larynx, and in a short time the patient, asphyxiated, succumbs.

I will ask any one of my readers, who has an opportunity of judging for himself, to watch closely and see if my statement cannot be verified. I do not for one moment wish it to be understood that all these signs can be seen in every case, because in some the changes occur very rapidly, and in others we are not called until the disease is well advanced; but I have seen these distinct stages so frequently that, reasoning from analogy, I am led to

believe that they occur in almost all (if not all) of them.

I wish clearly to point out that it is my experience and conviction that diphtheria runs a most definite course, and that therefore it is in the physician's power to detect it early, and to absolutely abort, or at any rate cut short, the attack. No doubt, as in all diseases, there are abnormal cases, but all must agree that the treatment becomes much simplified if we know that we are dealing with a definite disease, which, as a rule, runs a definite course, and springs from a definite origin (a micro-organism).

The most important points for a young practitioner to bear in mind are the insidiousness of the disease, and the remarkable freedom from pain referred to the throat. This alone seems to me sufficient to diagnose diphtheritic throat from almost any other affection there. Scarlatina, tonsillitis and ulceration are all attended with a considerable amount of pain, especially in swallowing, whereas in diphtheria the throat is in numerous instances not complained of at all, or only slightly, even when the affection has advanced to a dangerous degree. Hence it is that the malady may be overlooked, especially when some other epidemic, such as influenza, is

about. I must confess that I have on several occasions known persons to walk into my surgery during the late outbreak, and I have been on the point of declaring the case to be one of incipient influenza until I examined the throat, and, although not any pain was complained of, nor even inconvenience there, I have found on various parts of the fauces numerous diphtheritic patches.

It will now be my endeavour to prove that the disease can be aborted, or, at least, cut short. To effect this I must illustrate my remarks by putting forward some cases. If I can from them show that, by the treatment which I am about to advocate, I, in the first place, have attended one in the second stage (before exudation), and not let it reach the third stage (of exudation); and again one in the third stage, and not let it reach the fourth stage (of false membrane); and again one in the fourth stage, and not let it proceed any further, I feel that I shall have gone a long way towards proving my dictum.

Case I.—In August, 1892, I was attending a friend's child and one of my own. Both were similarly affected with febrile disturbance for about twenty-four hours. At the end of that time, that is to say, on the evening of the

second day, in both cases I found the submaxillary glands enlarged, and the throat dusky-red, with granulations, but no sign of exudation. I felt comparatively certain I was dealing with two cases of diphtheria, and put my friend's child under immediate treatment, and, to be brief, the malady did not develop at all, and the child made a speedy recovery. As my own child was under my immediate supervision, I decided to leave the treatment until the morning, and had her removed into a cot by my own bedside. In the short space of about four hours I was aroused by her stertorous breathing and ringing cough. On examination, I found that the soft palate, uvula, tonsils, and pharynx were thickly covered with false membrane, and that all the signs of laryngeal diphtheria were present. For seventy-two hours she hung between life and death, but by assiduous treatment she ultimately recovered, and is, I am thankful to say, strong and well to this day. Can there be any doubt that in the case of my friend's child the malady was aborted, and that my own child was saved by the treatment that I will set out? N.B.—No sequelæ occurred.

Case II.—On March 5th, 1893, Miss P——, living at S—— Road, came to me in company

with a trained nurse. From particulars that I gathered, I found that Miss P——'s step-sister, aged eight, had just died after tracheotomy, performed as the last attempt to save her life while the victim of diphtheria. This young lady had assiduously nursed the child, inhaling her breath, and being in every way subjected to the diphtheritic virus for fourteen days. As Miss P—— did not feel well, the nurse persuaded her to see a medical man, and they walked to my house. On examination, I found that every sign of a most severe case of diphtheria was before me. The fauces and surrounding regions were of a lurid red colour and highly œdematous, and from numerous points the exudation was springing forth. Immediate treatment was used and constantly repeated. No membranous patches formed (I may say, were permitted to form), and on the sixth day from her seizure I was able to pronounce her free from all danger from the primary attack. Up to the present there seems no sign of any secondary symptom. She subsequently developed erythema, from which she recovered in a few days.)

Case III.—Sister E——, one of the nurses attached to a mission here, was first seen by me on the 20th of October, 1892. In her case the

membrane had formed when I saw her. I need not go through details. Under treatment the membrane rapidly dissolved; the exudation continued till October 25th, when it disappeared, and she made a rapid recovery, without any sequelæ.

Case IV. was like this, except that one child in the house had already died, and when I was called the doctor in attendance had pronounced this case hopeless. As he retired from the case, I was obliged to attend it alone. This was a little girl called N——, whom I found in considerable danger, the membrane having extended to the larynx. In five or six days the membrane and exudation had disappeared, and she made a good recovery, without any sequelæ.

I could adduce numbers of other cases, but I have mentioned sufficient, I think, for my purpose. Has it not been sufficiently shown from a practitioner's test, namely, that of results, that the definition given by the author at first of this malady is correct, or that there are at least considerable grounds for such?

To recapitulate, I think it has been conclusively proved by me that the disease can be arrested in the throat, and from that I draw the

inference that the *primary* local seat of it is the throat, which was the problem I at first essayed to prove.

The late Dr. John Rose Cormack (Quain's 'Dictionary of Medicine') says that in 98 per cent. of cases the exudation commences on the pharynx or tonsils. May it not, therefore, be reasonably argued that in the remaining 2 per cent. the cases have run an abnormal course, or, as I have stated 'its appearance' elsewhere, may be attributed to 'continuity, or metastasis, or secondary toxæmia'?

Some may, and I expect will, object to my dividing the course of the disease into stages. I do not press the point, for it is comparatively immaterial to my argument; it suffices for me, if a malady is seen in a certain condition (be it stage or not), and, instead of going from bad to worse, is there and then arrested.

An illustration of this. A member of a family has been undeniably suffering from diphtheria, another member or other members take ill, a remedy is made use of, and in none of them the malady develops; although it may be difficult to say absolutely that the latter have had the affection, is there not ground for suspicion that such has been the case? This has occurred

in my experience time and again. May it not be claimed that some of the cases have been aborted by the action of the remedy?

Author's treatment.

It remains for me to bring the treatment forward. It has been pointed out that diphtheria has both general and local symptoms, therefore it requires both 'general' and 'local' treatment. In the former due regard must be taken to hygiene, diet and medicine. One of the first precautions is isolation, not delayed until the disease has declared itself, but put in force the moment it is suspected. The patient should be placed in a spacious room, with plenty of fresh air without draughts, and he should be kept warm, but not oppressively so. An equable temperature of about 60° Fahr. should be maintained in the room, and it is of advantage to have a steam-kettle. The diet must be highly nourishing and stimulating—milk and beef-tea, egg-flip, tea, coffee, meat-juice—and it is advisable that, as far as possible, the foods should be peptonized, as there is considerable derangement of the functions of digestion. I am not in favour of actual stimulants, such as brandy, etc., until they cannot be dispensed with, wishing to keep them as a reserve force. The medicine on which I rely is iron, and I generally couple it with chlorate of

General treatment.

potassium. If the case is seen early, mild diaphoretics and diuretics are required, such as acetate of potash and Mindererus' spirit. I consider antipyrin too depressing, and on that account avoid it. Later on, when convalescence arrives, quinine alone, or, better still, with iron, and possibly strychnine, are most trustworthy. The great thing necessary is to support the strength, and assist nature in repelling the poisonous character of the disease; therefore nervine tonics are the mainstay on which the physician must lean. Avoid emetics; they wear out the patient and do no good, as the membrane will almost certainly form again after their use.

Local treatment.

The *local* treatment on which I have entirely relied for more than five years is free and frequent insufflations of sulphite of magnesium (magnesii sulphis). During that time I have not lost one single sufferer from this malady, a record which will bear comparison with that of any practitioner operating with any other remedy. The moment I suspect a case I commence with it, and, as I have argued before, is it not fair to claim for my remedy that by its action some cases at all events have been nipped in the bud?

In those cases where exudation alone has

taken place, I have not in one single instance seen a formation of false membrane, and in those in which the false membrane has already formed, it is surprising how short a time it has taken to dissolve it, and in no instance has there been a return under the continued use of the insufflator.

In mild cases of diphtheritic throat, even when patches of membrane have formed, I have seen every vestige of them and of the exudation disappear in from forty-eight to seventy-two hours, and the worst case that has come under my notice since I commenced this local treatment has not had a trace of throat complication in a week.

It will be noticed that in bringing forward some of my cases I have in each of them pointed out that there have been no sequelæ. Herein, to me, lies the charm of the remedy. The micro-organism is absolutely destroyed, and does no more mischief.

The points, therefore, that I claim for this remedy, as before stated, are that it is safe, simple, efficient, a complete dissolvent of the membrane and a perfect bacteriocide in diphtheria, and, moreover, being in the form of a very fine and sparingly soluble powder, it is during inspiration drawn into the larynx and

bronchi, acting when other remedies will probably fail. Even with children there is but little difficulty in using it, an advantage that can scarcely be claimed for any of the other medicaments heretofore employed, although I have no doubt that in suitable cases they may be very effective.

The interpretation of the phrase 'free and frequent' use of the insufflator must be left to the discretion of the physician in charge. One cannot draw a hard and fast line, much depending on the severity of the attack. In mild cases it may not be necessary to call upon it more than twice or three times daily, and half a dozen times, or even less, may be as often as it may be required altogether. In severer attacks it should be used every one, two, or three hours, according to circumstances.

Messrs. Burroughs, Wellcome and Co., of Snow Hill Buildings, have prepared for me throat 'tabloids' of sulphite of magnesium, and they have also, at my suggestion, designed and perfected a powder insufflator, which I hope will be found very serviceable.

Let me say, in conclusion, that I shall be more than rewarded for any trouble I have taken if I am able to learn hereafter that anyone else has been as uniformly successful in dealing

with this direful complaint by this mode of treatment, or that my own opinion on the subject has been corroborated by the experience of the profession in general.

APPENDIX.

SINCE writing the above I have treated numerous cases of diphtheria, all with the same happy result, one of which I think worthy of recording as a further proof of the efficacy of the remedy.

On June 29th, 1893, I was called to see F. P—— at 6.30 p.m. I found the lad (aged sixteen) lying in a semi-conscious state, with his mouth wide open, scarcely able to breathe or articulate. On looking into his mouth, I saw that a large flap of diphtheritic membrane, which had become detached anteriorly from the palate, hung down on his tongue, completely obscuring the throat from view like a curtain. Having removed this with a spatula, I was able to examine the throat itself, and then perceived that all the parts there were thickly covered as if with wet chamois leather. I put him immediately under treatment — insufflations and

tabloids of sulphite of magnesium, chlorate of potassium and iron internally—and gave directions that his throat should be frequently gargled alternately with solutions of chlorate and of permanganate of potassium. On visiting him the next morning at 10.30 a.m., I was agreeably surprised to find that every particle of the diphtheritic membrane had disappeared; the throat showed the characteristic granular appearance and dusky red hue, with traces of secretion.

The treatment was continued until the 3rd of July (*i.e.*, five days inclusive), when I was able to pronounce him convalescent.

It is unnecessary for me to make any remarks on this case, which speaks for itself.

THE END.

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