

**A visit to the Reknaes Hospital for Lepers at Molde, Norway ; Notes on the successful treatment of obesity / William Allan Jamieson.**

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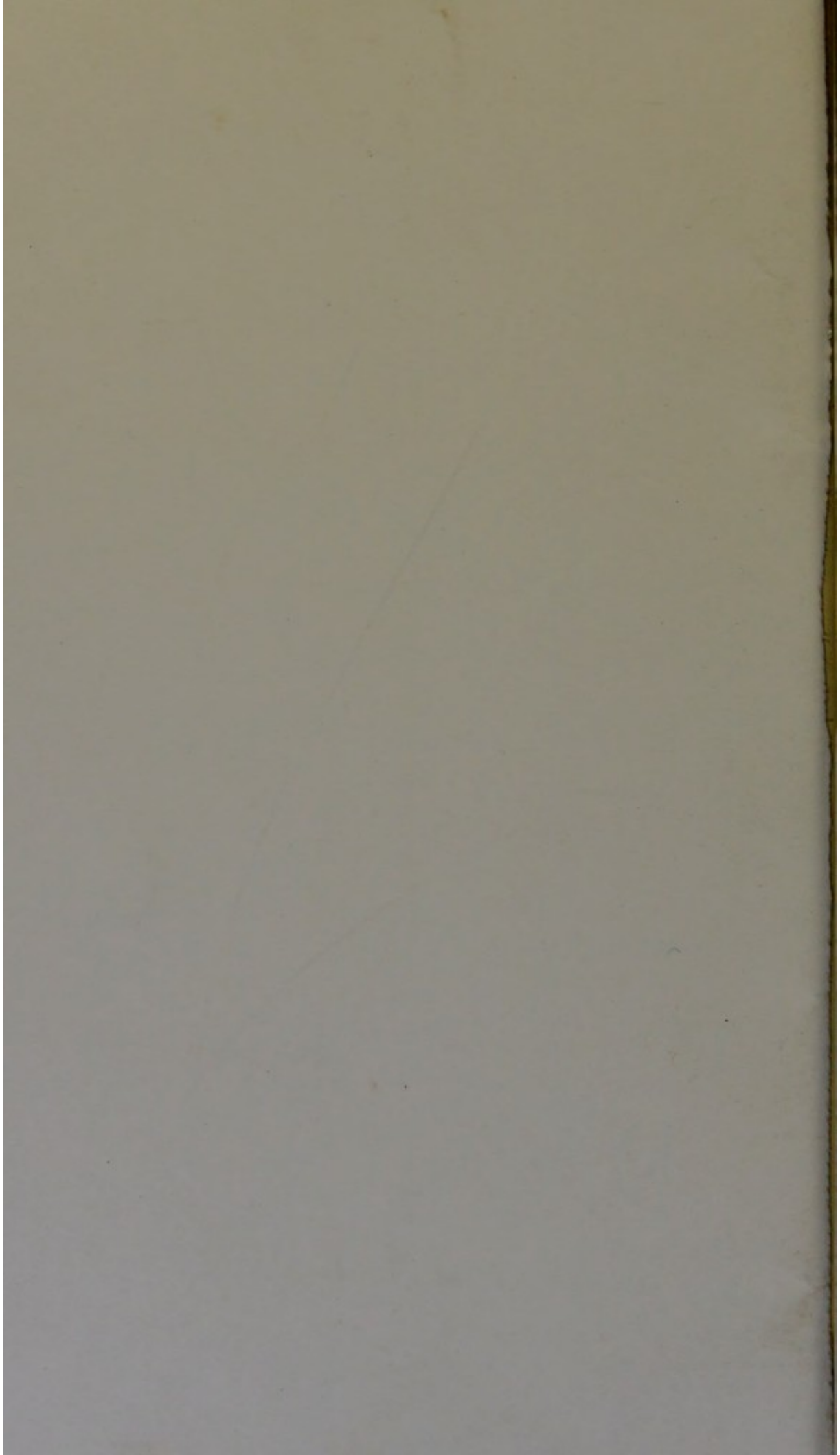
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A VISIT  
TO THE  
REKNAES HOSPITAL FOR LEPERS AT  
MOLDE, NORWAY.

NOTES  
ON THE  
SUCCESSFUL TREATMENT OF OBESITY.

BY  
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## A VISIT TO THE REKNAES HOSPITAL FOR LEPERS AT MOLDE, NORWAY.

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DELIGHTFULLY situated on the shores of the fjord of the same name, sheltered from the cold north winds by well-wooded hills 1500 feet high, nestling among trees of species which grow hardly anywhere else in Norway, with a milder climate than the majority of places in the same latitude, in front the ever-changing sea, studded with picturesque islands, and beyond this the splendid chain of the Romsdal Alps, stretching from east to west as far as the eye could reach, sending their countless peaks high into an atmosphere as clear and blue as an Italian sky, the little town of Molde, with its population of some 1700, appeared in August of this year (a month sunless and wet in Great Britain) indescribably charming. Yet there is a dark spot even in Molde,—a leper hospital capable of holding 160 patients, an indication that this loathsome and well-nigh hopeless disease, though steadily diminishing in the number of its victims, must still be regarded as endemic. And, indeed, a map prepared some years ago by Dr Kaurin, the distinguished physician of the Hospital, showing the distribution of lepers throughout Norway, plainly exhibited the fact that two spots present the greatest assemblage in the smallest area, the neighbourhoods respectively of Molde and of Bergen, though the reduction has been going on in recent times here as elsewhere.

At the west end of the town, in well-wooded grounds which slope gently up from the road running parallel to the fjord, and commanding an extensive view, is placed the Leper Hospital for the district of Reknaes, including Molde and Romsdal. It was originally founded in the year 1713, and was principally maintained from the revenues of lands which had been given or bequeathed to it. In 1861 it was replaced by the present and much larger one, built at the expense of the State. It is a two-storied building of wood, consisting of a central block with five wings, one of which is a neat and airy chapel, where service is held once a fortnight. The lepers are treated gratuitously, the expense being defrayed mainly by the State, but partially from the revenues of the old hospital.

The wards are spacious and well-ventilated, the male cases are placed in one wing, the female in the other, while the executive department is disposed in the central part. The education of the younger lepers is not neglected, for there is a school with all necessary appliances for teaching. The older inmates are occupied in spinning and in knitting the Norwegian wool. There was no over-crowding of the wards, and the national cleanliness was not less evident here than elsewhere. The number in hospital at the date of our visit was 79. In 1856 the total number of lepers in Norway was estimated at 2900, and since then this has steadily diminished, so that now it is calculated that they probably do not exceed 1000. The number in hospital, too, has varied to a considerable degree. In 1856 there were but 200, but in 1866 this had risen to 800, the highest it has attained. With the decline of the complaint throughout the country, the number in hospital has also lessened, so that now there are only about 500 availing themselves of the advantages of treatment and residence there. Removal into hospital benefits the patients themselves; they are there kept clean, their ulcers are carefully dressed, useless limbs or such parts as are the source of pain or distress are amputated, and thus their lives are prolonged and made more endurable. It at the same time is advantageous to the general population, by reducing the number of foci from which the disease may make fresh inroads, or attack new victims. Hence isolation has distinct merits of its own. Yet the decrease in leprosy in Norway cannot wholly be ascribed to isolation. In Iceland leprosy was at one time extremely widespread; there are now only about ten in the whole island, though isolation has never been carried out, nor has the condition of the people materially, if at all, improved. The influence of heredity *per se* is equally difficult to fathom. In the case of children their mode of life is essentially the same as that of their parents, while they are in more or less intimate and prolonged contact with them, still not all the offspring suffer even in instances where both parents are affected.

Dr Kaurin is a full believer in the communicability of leprosy. There are, however, some curious points with respect to this. In Norway no nurse nor any medical man in attendance on lepers has, so far as is known, ever yet contracted the disease, nor have any experimental inoculations on animals been successful. Physicians have inoculated themselves, their colleagues, and numerous healthy persons, introducing the leprosy material in the form of portions of the nodules under the skin, but no one so treated has yet become a leper. To communicate the disease two factors would appear necessary,—one, prolonged or very intimate contact with a leper, as by sleeping in the same bed, wearing the clothes of an affected person, etc.; the other, a peculiar condition of the system, probably induced by habitually partaking of a bad or at least unsuitable dietary. Mr Jonathan Hutchinson, as is well known, holds strongly

that "fish is probably the vehicle by which the poison of leprosy gains access to the human body."<sup>1</sup> Medical men have not yet generally adopted his view, but from several conversations which I held with intelligent Norwegian peasants as to their opinion of the cause of leprosy, it seemed evident to me that they were inclined to think that fish had at least something to do with its origin or spread. If such a view is, even to a limited extent, correct, there can be no true ground for any leprosy scare as far as this country is concerned. There is no reason to fear that, under existing conditions, leprosy will again obtain a hold in Great Britain. A physician who holds strongly the view that leprosy is non-communicable once visited a Norwegian leper hospital, and there ventilated his opinions freely and decidedly. "Will you then occupy a bed alongside one of these patients?" asked the doctor in attendance. "No," replied the anticontagionist, thus put to the proof after a fashion he did not anticipate, "I have a wife and children at home depending on me." He had not, and perhaps one could scarcely expect him to have, the courage of his opinions.

Ever since the discovery of the bacilli peculiar to leprosy by Hansen in 1874, a deep and increasing interest has been manifested in these micro-organisms. Dr Kaurin has a thoroughly equipped laboratory in the Hospital, in which he has carried on important investigations into the bacteriology of leprosy. He has recognised the resemblance which the bacilli bear to those of tubercle, though smaller and heaped up into groups instead of being scattered. He thinks, also, that they are contained within the cells, not outside them, as Unna has stated.<sup>2</sup> Dr Kaurin has found the bacilli in the spinal cord, and occasionally in the cerebrum, but it is rare for them to be met with in the central nervous system. He has examined the earth, water, and food with negative results; and on one of the days on which I visited the Hospital, I found him setting up an apparatus which he had just received for examining the air. When the difficulties which surround the subject are kept in mind, the wonder is that the bacilli should ever be discovered in these media unless by a fortunate accident; the traditional needle in a haystack is, compared with this, a comparatively simple matter. He has not succeeded in cultivating the bacillus, and has come to the opinion that perhaps there is some intermediate stage through which it passes, or some undiscovered host in whom it undergoes a further development not yet unearthed. I observe that Dr Beaven Rake has enunciated a similar theory.<sup>3</sup>

The incubation period of leprosy is almost certainly a long one.

<sup>1</sup> *Archives of Surgery*, vol. i., Appendix, "The Leprosy Problem," p. 11, 1889.

<sup>2</sup> "Wo liegen die Leprabacillen?" *Deutschen Med. Wochenschrift*, No. 8, 1886.

<sup>3</sup> *Report on Leprosy and the Trinidad Leper Asylum for 1889*, p. 7. Port-of-Spain, 1890.



Dr Kaurin stated it as probably from three to four years. He has never seen a case in very young children, in cases even where the parents were lepers. The disease sometimes manifests itself as early as at the age of 5, more commonly between 15 and 20, but it may declare itself at any age. Thus he showed me a patient 70 years old, affected with the non-tubercular or anæsthetic form, who had suffered from the symptoms for only two years. The maculæ were well-marked on the flanks—the centres, as usual, after a time being anæsthetic, the peripheral portions hyper-æsthetic, while on the lower dorsal region were leucodermic spots, which had resulted from the absorption of previous maculæ. The duration varies, in some instances as much as forty years; more usually they succumb to it in from nine to fourteen years. A frequent termination is phthisis; and, indeed, the resemblance between phthisis and leprosy has been pointed out by more than one observer. The precise diagnosis of leprosy, even in a country where it is prevalent, is not by any means so easy as would at first sight appear. An old woman was in hospital for observation. She had on the limbs and neck large brownish-red erythematous blotches, each irregularly rounded, and presenting considerable resemblance to a macular syphilide. Yet in this case syphilis could, Dr Kaurin assured me, be absolutely excluded. This condition had lasted one year. There was no anæsthesia, or if any, the merest trace in the centre of some of the patches. A small portion of skin removed from above the eyebrow, so frequently one of the earliest situations for leprosy to manifest itself, was found not to contain bacilli. The disease in this instance was probably a chronic erythema multiforme.

The tubercular form is by far the more common, yet in hospital the number of anæsthetic cases nearly balanced the tubercular. When the mixed form is met with, the tubercular usually precedes the anæsthetic in point of time, but this is occasionally reversed. The tubercular exhibits the greatest variety in the appearances. The colour of the tubercles as seen fluctuated between a pinkish hue and a brownish-red tint. Sometimes much, at other times little, pigmentation followed the absorption of the nodules. Ulceration and caries in place of atrophy succeed. The cartilages of the nose are destroyed, and an aspect not at all unlike that which may be occasioned by tertiary syphilis is assumed, or the skin becomes tightly bound down over the facial bones, acquires a bluish-lead hue, and the general effect is extremely ghastly. The cornea is specially apt to become the seat of tubercles, sight is usually lost, and the optic nerve may be involved secondarily. Sometimes a mere stump remained, in other cases the corneal ulcer healed, and the eyeball, shrunken and sightless, was still in place. Tubercles do not readily form on the scalp, hence the hair there continues, but the eyebrows in both sexes and the beard in men either wholly or in great part fall off. Febrile accessions are common, due in some cases to the eruption of fresh tubercles, in others to the in-

vasion of phtlisis. There are occasional complications; thus in one woman I noticed acne rosacea in conjunction with leprous tubercles on the face. Caries of the bones of the feet may occur. Dr Kaurin showed me some most interesting specimens in his museum; one was a foot in which only the os calcis and the atrophied remains of some of the phalanges were distinguishable. Leontiasis was well-marked in some; in others, also examples of tubercular leprosy, it was scarcely discernible. Though present to a slight extent, in no case was leucoderma at all a marked feature, and "the leper white as snow" was not recognisable.

The non-tubercular or anæsthetic type is perhaps the more interesting of the two. In some cases maculæ, which are at first hyper-, and later an-æsthetic, are the earliest symptoms; in others the anæsthesia seems to be the first thing to attract notice. It is a well-marked phenomenon, so that amputation can be performed on parts where it is pronounced without chloroform. A noticeable feature is the atrophy of the thenar and hypothenar muscles, the contraction of the flexor tendons of the fingers, and a gradual digital osseous wasting. This latter begins in the distal phalanges, which become thinner and thinner till they disappear. Then the second phalanges are affected, and undergo a similar destructive change. Sometimes the pulp of the finger remains with the nail attached on the shortened digit; at other times the finger looks as if amputation had been skilfully performed, and a well-shaped stump results. Severe neuralgia, usually of the sciatic, is common, only to be relieved by the removal of the limb. The tendon reflexes are abolished when the anæsthesia is fully established. Perforating ulcer of the foot not unfrequently occurs; this is also seen in locomotor ataxy, and the neuralgia in leprosy may also be contrasted with the lightning pains of tabes. Ectropion also occurs, but its disastrous effects on the eye can be much lessened by blepharoraphy. Dr Kaurin frequently performs this; he makes the edges of the eyelids raw on their inner third, then stitches them together; the puncta lachrymalia are in this way obliterated, but no stillicidium follows.

The treatment of leprosy in the Reknaes Hospital consists mainly in relieving symptoms. Dr Kaurin has tried ichthyol, but without definite result; and the same may be said with regard to chaulmooghra oil. Patients as a rule are too late of coming in for treatment. That much might be done were cases received earlier was proved by the improvement in two instances which had offered themselves soon after the commencement of the complaint. One of these was a woman, aged 19, admitted four years previously. She had then suffered for one year from the anæsthetic form, with many maculæ on her shoulder's. Under good diet, baths, and a generally well-directed hygiene, all these had disappeared. She looked cheerful and plump, with a mere trace of anæsthesia persisting on the hands. The other was a boy, aged 14, who had had the

tubercular form for five years. He, too, had now no tubercles, their situation being represented by slightly puckered scars. Both were in a fair way towards complete cure. Melancholy as was undoubtedly the state of many of the patients, one could not help mentally contrasting their condition with that of those who could not have the advantages of skilful management in hospital.

## NOTES

ON THE

# SUCCESSFUL TREATMENT OF OBESITY.

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THE *raison d'être* of this brochure requires a word of explanation, since I make no claim to any special acquaintance with the measures best suited for the reduction of *embonpoint* either in men or women. My friend of more than twenty years' standing, Dr Turnbull of Coldstream, had invited me to spend a couple of days under his most hospitable roof. I had not failed to observe for some time past that there was a distinct process of shrinkage in bulk going on in Dr Turnbull, and had indeed watched the diminution with no small degree of anxiety. When, however, I quoted Sir Douglas Maclagan's well-known lines—

“Guidman, are thae some borrowed claes,  
An' are your ain awantin' ?  
Or ha'e ye fa'n awa frae these ?  
Is this the wark o' Bantin' ?”

Dr Turnbull assured me that there was no ground for concern on his account. He had tried Mr Banting's plan in former years, but it did not suit him. He certainly did get thinner, but his health, his spirits, and his enjoyment of existence on the convex surface of this little planet all failed, and he felt himself, and his friends feared even more strongly, that if the procedure were to be persisted in for any time, his premature departure into the unknown was inevitable. He had now, he informed me, fallen on a much more thorough method, one which while it was steadily decreasing his weight, was at the same time rendering him more active, and increasing his zest for life. He told me that many of those who had seen the improvement had urged him to publish the details of the system which had done so much for him, but he had an invincible objection to appear in print. He offered, notwithstanding, to supply me with notes of the plan, if I would prepare them for insertion in the *Edinburgh Medical Journal*. As will be seen from what follows, given almost in Dr Turnbull's own language, another besides himself has already benefited.

James Downie, now aged 52, left Berwickshire for Leicestershire twenty-three years ago. He was then in good health. His habits were active, and he was strictly temperate. Six years subsequently he had an acute attack of gout, and was confined to bed for at least a month. From four to six times a year he had similar attacks, usually having a duration of two or three weeks. A couple of years later he had an excessively severe seizure, which necessitated his stay in bed for six months. He went, after he became convalescent, for six weeks to Buxton, where he greatly improved, but on the day after his return to Leicestershire he had a fresh outbreak. About fifteen years since he became utterly incapacitated for work, and had to resign his situation of stud-groom. He was now more or less confined to bed, or at best could not walk save with the aid of crutches. In 1885 he returned to Coldstream, but was seldom able to rise from his couch. From November 1887 to December 1889 he was constantly confined to bed and utterly helpless. During his illness he had consulted several physicians, and had taken an immense quantity of medicine. He believed that in the end of 1889 he weighed about 22 stones, and judging from his appearance, etc., his estimate was probably pretty nearly correct.

Reverting to Dr Turnbull's own case, in consequence of suffering from great dyspnoea, Dr Turnbull consulted Dr G. W. Balfour in June 1889. He then weighed 22 stones. He was advised to change his mode of living, and to place himself on a regulated dietary. Acting on his advice, Dr Turnbull says—"I breakfasted at nine as usual, took an egg, half a slice of toast, and a small cup of tea. At two a small basin of soup with a piece of toast. Dinner was at eight, when I had a little fish, the wing of a chicken, or an equivalent in mutton, with some green vegetables, and a very small bit of cheese with biscuit. After dinner I had half a glass of whisky in half a tumbler of water, and one cigar, partook of no soup nor pudding of any kind with dinner. Under this system I steadily lost weight, so that on the 5th of December last I found that I weighed 17 stones 10 pounds. I gave up drinking any fluid during the day, and my weight at present (in the middle of September 1890) is 15 stones 7 pounds—thus I have lost in the course of about fifteen months 6 stones 7 pounds.

"Having thus so greatly benefited myself, I felt very sorry to see poor Downie so utterly helpless, and therefore proposed to him that he should try my plan of diet. He readily agreed to follow my advice, being encouraged by seeing for himself the difference in my size. He adopted the method in December 1889, when he weighed, according to his own estimate, 22 stones. His exact weight now is 16 stones 10 pounds. From being quite unable to assist himself in any way, he can now walk about with the help of a stick. He had been a great water drinker, so he suffered very considerably for nearly a month from thirst, but he resolutely

refrained from yielding, and now he feels no desire for liquids. In nearly every detail his diet was such as I had adopted, only he had neither whisky nor tobacco.

"When, by the urgent advice of the late Dr Warburton Begbie, I gave up the Banting system of reducing corpulence and resumed my usual diet, I very rapidly became heavier than before. I am satisfied now that the easiest way to lessen obesity with safety is to reduce the quantity of food, and especially of drink, to a minimum. A moderate amount of butter and fat should be taken daily. Sugar and starch ought to be avoided as far as possible, while potatoes and bread must be refrained from absolutely. Vegetables, however, are not contraindicated, but those which are most suitable are onions, leeks, spinach, stewed celery, cauliflower, brocoli, Brussels' sprouts, asparagus, young cabbages, and such like. From much observation, I am quite confident that fresh salmon, properly cooked,<sup>1</sup> with no lobster or other sauce than the water in which it has been boiled, and eaten without potatoes or other objectionable vegetables, in moderate quantity is *a perfectly digestible fish*, notwithstanding all that has been written to the contrary.<sup>2</sup> An occasional warm bath is to be recommended, and some such laxative as a seidlitz powder may be prescribed along with the diet I have indicated. *Moderate* exercise only should be taken."

The plan of treatment which Dr Turnbull and James Downie have found so beneficial is one not altogether unknown, though the rationale may be more difficult to explain. Thus Dr Mitchell Bruce says,<sup>3</sup> "A copious supply of water increases nutrition up to a certain point, especially the deposit of fat, and is therefore extensively employed in hydro-therapeutics." And again Dr Thomas King Chambers remarks,<sup>4</sup> "Where heart disease is

<sup>1</sup> Salmon, however, is seldom properly boiled, save on the banks of the river Tweed, or by those who are acquainted with the plan of treating the fish before boiling, and of cooking it, which prevails there. The fish, as soon as possible after having been caught, must be "crimped," that is, it must be split up longitudinally along the back, then cut crosswise into pieces of just such a size as to form a portion suitable to help to each guest. When the fish is to be cooked, the water in the fish kettle, to which twice as much as two conjoined hands can lift of salt has previously been added, is brought to the boil and the pieces of fish put in, arranged upon the drainer just as they are afterwards to be placed upon the dish. The water is again brought fully to the boiling point, and kept so assiduously by the cook for five minutes. At the termination of that period the fish-kettle is removed from the fire, and the fish taken out upon the drainer. If these details are attended to, the salmon will be boiled to perfection, and will be found not only perfectly digestible, but possessing a delicacy of flavour not brought out by any other method. To boil salmon whole, as is frequently done, is simply to do an injustice both to the fish and to the person who is to partake of it.

<sup>2</sup> Even Dr Burney Yeo, in formulating some rules of dietary in obesity, which correspond on the whole pretty closely with those laid down by Dr Turnbull, says, "Eels, salmon, mackerel, are best avoided."—*Food in Health and Disease*. Cassell & Co., 1889.

<sup>3</sup> *Materia Medica and Therapeutics*. Sixth edition, 1888, p. 151.

<sup>4</sup> *A Manual of Diet in Health and Disease*, 1875, p. 342.

complicated with obesity, especially if the fat is accumulated in the chest, the enforcement of a dry diet is still further to be viewed as imperative, inasmuch as it contributes powerfully to the reduction of the hypertrophied adipose tissue." In all cases a most important point would seem to be the separation of the ingestion of solids and of liquids in regard to time. Thus any liquid should be taken in the interval between meals, and not at the time of or along with solid food. The observation of a dry diet contributes greatly to the comfort of obese patients, and, as has been seen, is in itself curative.

