count of the emphasis placed on the need of careful examination and definite diagnosis in recurrent attacks of so-called colic.

Colic, as he brings out, is usually caused by exacerbation of subacute conditions or recurring acute trouble. Also the underlying cause is often of a very serious nature.

One cause for recurrent colic which is rather frequent has not been discussed, namely, pylorospasm. This is encountered not infrequently. It may or may not be accompanied by vomiting. In some of the children a history of vomiting during the first three months is given, but not later. The attacks are intermittent and usually occur soon after feeding. X-ray will show a very slow emptying time for the stomach. The attacks are usually relieved by small doses of atropine before feeding, or in more severe cases by ⅛ to ¼ grain doses of phenobarbital with or without atropine. It would be well to exclude pylorospasm in all cases of colic where the diagnosis is obscure.

However, I feel that, as stated before, the chief value of Dr. Scott's paper is to emphasize the fact that recurrent pain should be given the same searching clinical consideration in early childhood as would be given to similar symptoms in the case of an adult.

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Doctor Scott (Closing).—I wish to thank the men who have discussed this paper. My object in bringing this before the section was to provoke discussion and remind us that there are other causes than food which may cause colic in infants past the first three months of life. We tell our students to strip the child, examine the ears and the urine. If these admonitions are heeded there should be fewer errors in diagnosis and fewer important points overlooked.

A PROFESSION WITH A SOUL*

By W. H. Hood, M. D.
Reno, Nevada

GREAT has been the progress of medicine in the last century. Greater still has been the progress of our profession since the illustrious Lister applied the principle of Pasteur, scarcely two decades before the organization of the Pacific Association of Railway Surgeons some twenty-eight years ago. And even greater will be the progress in the days to come, for today in hundreds of laboratories there are thousands of investigators following in the footsteps of other pioneers, and to these future investigators honor will also be given, for through their efforts scientific medicine will continue to advance.

The clerical profession deplores today what it terms our material age, in which the chief aim in life is apparently the obtaining of wealth with which to gratify the body, without regard to those deeper pleasures of the mind or soul which money cannot buy. So the thought sometimes comes to me that, unmindful of the biblical injunction that "Man cannot live by bread alone," many in our profession may become so materialistic that they overlook the fact that our profession should possess a soul as well as a body—a soul that is over and above and which cannot be measured by the material scientist with his instruments of precision. Our service to humanity will be fuller if this soul element be not ignored.

Today there are many cults and systems of healing competing with scientific medicine. That such have many intelligent followers there is no denying. If they seem to their credulous followers to succeed, is it not perhaps, because they have capitalized an element that we have been too prone to neglect?

As I grow older in the practice of medicine, and in the experiences of life, I feel more and more the importance of this soul element in medicine. My thought to you today is that we, who from habit are concerned largely with the material elements of the body, may gain in value by keeping in mind this undefined soul which exists also in our patients as it is partly evidenced through the psychical element in disease. We all are familiar with the effects of a sick body on the mind, but we sometimes seem to forget that as great, or greater, are the effects of a sick mind on the body.

In our school days we were taught that a perfect bodily function depended upon healthy organs, upon a healthy supply of blood to these organs, and upon a healthy nerve supply to these organs. By nerve supply I do not visualize an inert wire that conducts an impulse, but the living battery that generates it.

As you well know, we have in the brain two sets of nerve centers: the upper nerve centers which have to do with thought, intelligence, will power, memory, and the like; and the lower subconscious or medullary centers, through which the upper nerve centers act. This is a wise provision of nature, universally observed. For example, when the student of music learns to play the piano every key that he strikes, every note that he sounds, is a conscious effort, and is followed with fatigue; but when, in time, by constant practice, he masters the instrument, with only the decision of the will to do, these lower centers act automatically and he plays even the most complicated compositions of the great masters without effort and without fatigue.

To apply this example, what happens in health or normal processes may also happen in sickness. In your own experiences you have seen how these subconscious centers act viciously, with symptoms continuing long after the cause of the illness is removed. These unfortunate patients need mental and not physical treatment. First of all let the physician make a complete examination, using the aid of all scientific tests, so that he can be sure of his position; for if the physician is not confident he is in no position to inspire confidence in the patient. With sympathy, then, assure the patient that his trouble is not imaginary but real. Then trace the progress of the illness from the beginning and illustrate how the subconscious center acts automatically in the ordinary pursuits of life. To obtain a cure it is necessary to reeducate the patient to bring this center into normal action. This cannot be done by an effort of the will power, for trying to do a thing expresses in itself an element of doubt of success, but it can

* President's address at the twenty-eighth annual session of the Pacific Association of Railway Surgeons, August 23, 1930, at Coronado, San Diego.

be done by cultivating an attitude of complete indifference, neither anticipating nor recalling the symptoms.

Doubtless many of you have had a similar experience to the one I am about to relate, an experience that started me on this line of thought. More than one-third of a century ago I was called to a little mining camp to attend a young girl with appendicitis. According to the standard treatment of the day, I purged her with free doses of Epsom salts, advising her to come to Battle Mountain (where I was then located) in two days for observation, with the possibility of sending her to San Francisco for an operation. The young lady came for observation and continued on to San Francisco. One of the famous surgeons there kept her under observation for another week, when he operated; but with the usual remark as often heard by country doctors, "You came just in time, another day would have been too late."

In a short time this emotional girl (we are all emotional) returned home in good health, and carrying as "Exhibit A" her appendix preserved in a bottle. Her mind or brain was filled with her new experiences—her operation, the first trip on the railroad train, her visit to San Francisco—experiences of which she talked continually. Her good health continued for several months, when she began to suffer with so-called gas pains and adhesions. As soon as finances could be arranged she renewed that wonderful experience—that trip to the hospital. Three times the operation for adhesions was repeated, each time with relief for a year or two, when the trouble would recur. But financial reverses prevented further operations and the suffering continued. After some years, report came that she was completely cured and became a useful member of society, a wife and mother. Inquiry revealed that the miracle was performed by the use of the "Ouija" board.

All of us at some time or another in our practice might recall similar experiences. We know that there is more than a scientific and materialistic side to medicine. We know that medicine has a soul.

I hope that you have been interested in my theme. I advance my theme, "A Profession with a Soul," in all sincerity, after a lifetime devoted to the active practice of medicine.† Many of you may be in hearty accord with me, others may disagree. I have one consolation, however. You remember, in the essay "Cicero De Senectute" the pleasures of old age and the bliss of the hereafter are depicted, the essayist adding that if he was in error concerning immortality he had one happy thought, that there would be none of his critics there to ridicule him. So, knowing that the president's address is not open to discussion, I am in the same favorable position, for if I am wrong in this my belief I am happy in the thought there is no one here who will be allowed to call me to task.

Farmers and Merchants National Bank Building.

† Editor's Note.—Doctor Hood has the distinction of having been the first physician to receive a license to practice in Nevada.

OCULAR FINDINGS IN DIABETES*

COMMENT ON AN UNSELECTED GROUP OF ADULT DIABETICS

By H. Clare Shepardson, M. D.
and
Joseph William Crawford, M. D.
San Francisco

Discussion *by George Newton Hosford, M. D., San Francisco; M. F. Weymann, M. D., Los Angeles.*

DISTURBANCES of the visual apparatus are associated more commonly with diabetes mellitus than with any other systemic disease, with the possible exception of arteriosclerosis. Since Edward Jaeger first noted the presence of retinitis in diabetics about seventy years ago, many studies of ophthalmic lesions associated with that disease have appeared in the literature. However, few of these studies have been sufficiently comprehensive to include all the abnormal ocular findings. Of even greater importance is the fact that sufficient effort rarely has been made to determine the extent to which diabetes is responsible etiologically for diseased conditions confined to the eye. If the ocular disturbances are to have diagnostic value, it must be shown conclusively that diabetes, rather than an associated condition, is the causative factor.

SCOPE OF THE STUDY

It therefore seemed advisable to undertake a detailed study of the eyes in a group of unselected adult diabetic patients for the purpose of determining the incidence of ocular complications. Sixty-eight patients were included, among whom twenty-four were males and forty-four were females. The ages varied from eighteen years to seventy-nine years, the average age being fifty-four years. The only patients excluded from the series were those with acromegaly and exophthalmic goiter. In addition to a detailed and complete examination of the eye, every effort was made to discover systemic complications which might be associated with the diabetes and be exercising a causative influence in the production of the ophthalmic findings.

The diagnosis of diabetes mellitus was based on the presence of glycosuria and a postprandial glycemia above 150 milligrams, or a fasting blood sugar above 120 milligrams per 100 cubic centimeters.

The highest blood sugar obtained during the period of observation in this clinic was .559 milligram per 100 cubic centimeters. Due consideration must be given the fact that in certain instances the diabetes was well controlled at the time of entry, so that the blood sugar shown does not offer a true criterion of the severity of

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* Read before the Eye, Ear, Nose, and Throat Section of the California Medical Association at the fifty-ninth annual session at Del Monte, April 28 to May 1, 1930.