IMPAIRMENT OR LOSS OF THE SENSE OF SMELL AS A MEANS OF DIAGNOSIS.

Mr. W. Spencer Watson says that dyosphresia or impairment of the sense of smell, distinguished from anosuria, or total loss of that sense, is not easily estimated. Dyosphresia is a common congenital defect, and is not of much value as an indication of disease. Still, when the taste for flavors and the sense of smell are strikingly impaired, it is well to look for local obstructing cause. An ordinary catarrh may temporarily deaden the senses of taste and smell. If there is frequent intermittent failure of taste and smell there will generally be found some form of chronic rhinitis, and the most common form indicated by this symptom is that associated with gelatinous polypi. Other forms of nasal stenosis may produce anosuria more uninterrupted. Where no obstruction is found chronic atrophic rhinitis, ulcerations, necrosis and caries may lead to the same symptom, as well as facial paralysis with involvement of the fifth fasiculus. But anosuria is, medically speaking, a more serious symptom when it is not to be accounted for by any local disease of the nostrils. It may indicate intracranial disease or injury. Should the symptoms come on suddenly, after a fall upon the back of the head, it may indicate a separation of the olfactory bulbs from the lamina cribrosa, or the injury may have been more extensive and involve the cerebral olfactory centre, which is situated in the tempero-sphenoidal lobe. Drs. Hughlings Jackson and Beevor presented a case illustrative of this point. Perversion of the sense of smell in this case was noted as a prelude to epileptic fits, which preceded the gradual access of dementia, ending fatally; and in the *post-moriem* inspection a tumor, involving the tempero-sphenoidal lobe, was found. In any case similar to the above, in which the olfactory aura is marked, it is a question whether the case should not be handed over to the surgeon, for the purpose of trephining and endeavoring to find the cause of the mischief. In certain cases there is some hope of remedial treatment, but when this symptom is complicated with epilepsy or insanity, the probability of some tumor or disease in the vicinity of the tempero-sphenoidal lobe will suggest itself. Should there be a syphilitic history, the probability is in favor of a gumma, and treatment, if successful, will confirm the diagnosis. The possibility of optic neuritis being present should not be overlooked, and it should be a part of the routine practice in all these obscure cases to examine the retina ophthalmoscopically. —*Annals of Surgery.*

In an excellent paper on "dose dispensing" by Dr. A. B. Somers (now of Omaha), he says: As the years go by I have more and more reason to respect the effect of small doses of medicine often repeated. If some of my older friends are skeptical on this subject, let them try the effect of small doses of tartar emetic (gr. 1-100 to 1-50) in a case of acute bronchitis, with high fever, repeated every half hour from twelve to twenty-four hours, and see the direct sedative effect it will have on the mucous membrane of the lungs and air passages, accompanied by lessening of frequency of pulse and diminution of temperature; or in case of acute dyspepsia usually denominated bilious attacks with fever, try the effect of calomel gr. 1-10, alternated with ipecac gr. 1-10 and bicarbonate of soda grains ½ to ⅓ every two hours, and see how a single grain each of calomel and ipecac, with less than ten grains of soda bicarbonate, will reduce the temperature and produce even more copious discharges of bilious matter than we are in the habit of getting from large doses of calomel, or vegetable cathartics, and without any of the griping and uncomfortable symptoms usually accompanying the powerful doses; or to illustrate further, try in the first case of hepatic colic, or severe pain you meet with, the almost magical effect you will get from morphia gr. 1-20 to 1-40 combined with tartar emetic gr. 1-50 to 1-100 and administered every five minutes. Hypodermics of morphine in much larger doses are scarcely more effective.—*Western Med. Reporter.*

IODIDE OF POTASSIUM FOR THE DIAGNOSIS OF PHTHISIS.

Sticker renews an observation made by him a few years ago, which he has in the meantime confirmed and successfully used for the diagnosis of doubtful phthisis. He finds that where a lesion exists at the apex of a lung, suspected by an impairment of resonance, and alteration in pitch, or a harsh respiratory murmur, but without rales or blowing murmur, the latter may be produced by giving, for a few days, small doses of iodide of potassium. It seems as if the drug stimulated secretion, especially in the neighborhood of diseased tissue, thus giving rise to rales. If moderate doses of the iodide be administered to a healthy person, no changes can be detected in the lungs; but in a case of diffuse dry bronchitis, in the course of a few days an extensive moist catarrh, with fine and coarse moist rales, results. Similar manifestations appear in the area of circumscribed pleural adhesions or pleuritic roughenings. Not rarely the evidences of local reaction are gradually obscured by the signs of diffuse catarrh. In four cases of suspected tuberculosis, in which repeated physical examination of the lungs proved negative, the administration of the iodide for diagnosis purposes produced distinct signs of localized reaction in one or both apices, with tuberculosus sputa.—*N. Y. Med. Jour.*