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## Original Communications.

### ABSTRACT OF A PAPER ENTITLED OBSERVATIONS ON THE TREATMENT OF FIBROIDS OF THE UTERUS.

Dr. O. S. Phelps of New York (*Am. Medico-Surg. Bull.*) reports an unusually complicated case of uterine fibroid in a girl 17 years of age who came under his care in July, 1894. She was sent from the West to New York by the family physician to have a hysterectomy performed, and came directly to his sanitarium. The tumor was 8 to 10 centimeters in diameter, and crowded the uterus well over to the left side. The uterine cavity measured 5 inches, and the organ with its appendages was surrounded and bound down by an inflammatory exudate. The bladder was impinged upon so that it could not hold more than one or two ounces of urine, causing the patient great agony to evacuate it. The whole mass, including tumor, exudate, uterus and appendages, filled the pelvis, and rose well up to the umbilicus.

The patient was much emaciated, weighed 60 lbs. (normal weight 125 pounds), could not stand or walk, nor could she turn in bed without great pain. Temperature 100° to 103°. Dr. A. H. Goelet was called in consultation, and confirmed the diagnosis; he also agreed that no operation could be considered at that time, but thought ligation of the uterine arteries might be resorted to later. The treatment adopted was the high tension faradic current, 15 minutes thrice daily, vagino-sacral and abdominal. At each séance the temperature was reduced ½ to 1 degrees, lasting 1 to 2 hours. A system of feeding was adopted under the guidance of microscopical observations of the blood and secretions to determine the correct choice of food. In two months the temperature remained normal, and the weight had increased 30 lbs. Galvanism was then begun, with anode to tumor per vaginum, by means of a special clay electrode with cathode closely adapted to tumor over abdomen; -20 to 30 milliamperes of current, 7 to 10 minutes every five days. January 15, tumor was reduced to a mere nodule, about the size of a small

walnut, exudation gone, uterine cavity measured  $2\frac{3}{4}$  inches. Patient's weight was then 125 pounds.

Conclusions, the writer ascribes the favorable results in this case :

First, to a systematic plan for restoring the nutrition, under such favorable conditions as are afforded by a sanitarium.

Second, to the persistent use of the high tension faradic current to allay pain, reduce inflammation, and induce absorption.

Third, to the galvanic current, so applied as to concentrate its action upon the fibroid growth.

## Society Proceedings.

### MONTREAL MEDICO-CHIRURGICAL SOCIETY.

*Stated Meeting, November 30, 1894.*

G. P. GIRDWOOD, M.D., PRESIDENT, IN THE CHAIR.

Dr. ADAMI, reporting on Dr. Bell's cases, remarked that with regard to the first specimen, the portion of the intestine removed had been examined by Dr. Shaw, who made a series of sections, which showed that the cicatricial band in the intestines was not of the nature of simple fibrous tissue, but of fairly fibrous columnar-celled carcinoma. The post-mortem, which was made several hours after death, took place on Sept. 15th. Upon opening the abdomen, acute inflammation was noticed throughout the abdominal cavity. Fæces were first seen coming up through the region where the drainage tube had been, with gas bubbling up through them. Working down in this region they came to the sigmoid flexure, and the portion of the intestine where the "button" had been inserted, and found that sloughing had taken place between the upper half of the button and the attached intestine, which opened up the bowel, and allowed its contents to escape. The mesentery in the region of the slough was enormously thickened. It seemed to Dr. Adami that the slough had occurred more in the region of the rectum than in that of the sigmoid flexure.

Dr. SHEPHERD congratulated Dr. Bell on his success in the last case. The fatal result in the first he thought was not the fault of the operator, but was owing to circumstances over which he had no control. It would be interesting to know what caused the non-union of the bowel.

He had performed several operations of resection, but had always done the end to end suture. His difficulties had been with the mesentery, which tears, especially in regions where it is short, such as near the ileo-cæcal valve. The use of the clamp is another difficulty. Very little pressure is required to keep the bowel closed while the resection is progressing, and some instrument which will exercise exactly the right amount is much needed. He either used a rubber tube, or the hands of the assistant; the latter are best, but they are apt to be in the way; the rubber tube often exercises too much pressure. It is not the actual approximation of the bowel which takes up the time, but these other difficulties, which will exist just the same, notwithstanding the use of the Murphy button.

Dr. JAMES BELL, after explaining the manner in which the Murphy button was used, remarked that in the old method of simply suturing, he always felt considerable uneasiness as to the danger of the sutures giving way. It was true he never had such an accident occur in any of his cases; but when one considered the friable nature of the tissues united, it was not an improbable danger, and the increased security which the "button" gave in this respect was an advantage in addition to its saving of time. In concluding, Dr. Bell remarked that he began to use the Murphy button with some prejudice against it, but after trying it, he was bound to admit it a very useful instrument indeed.

Dr. ADAMI, commenting on Dr. Bell's theory as to the cause of the sloughing in his fatal case, said that at the post-mortem the glass tube was found rather to one side of the bowel, towards the middle line. It was found passing down to the portion of the bowel which held the button, which latter could be felt at the end of the tube when it was pressed down into the wound. It is possible, therefore, that there might have been some undue pressure on the bowel between the button and the tube, but as the tube at most could, from its position, press against the inner (or medial) side of the intestine, and the gangrene was equally developed all round the organ, save at the mesentery, it seemed to him more probable that the cause of the sloughing was the pressure of the elastic ligature on the intestine during the operation.

Dr. ARMSTRONG remarked that he had no special experience with the Murphy button; but that he had this last summer seen one post-mortem where it had been used, and where a good deal of sloughing had taken place around it. He frankly admitted himself a little prejudiced against the instrument. He did not think it saved much time, it could only economize in this way, in the matter of suturing, and in operations of this kind, his experience was that it was not the end to end suturing which caused most trouble in competent hands, but the dealing with the mesentery. The old me-

thod had given good results, and when properly performed, leakages from the bowel very seldom followed the operation. He, however, could conceive of cases where the button might be an advantage, namely, when resection had to be performed in portions where the bowel was not easily accessible to the hands, such as deep down in the pelvis; but in any situation where the intestines could be brought up, and conveniently sutured, he would prefer the old method. His great objection to the "button" was the manner in which it separated. This must of necessity be by a process of ulceration, which seemed to him a very undesirable condition occurring around the two ends of a lately united bowel.

Dr. JAMES BELL closed the discussion by answering some of the principal objections to the use of the Murphy button, and giving a brief *résumé* of the complications existing in his fatal case. It was easy, he said, to see why the button did not in this case come away. In the first place, he had narrowed the bowel before it, and in the meantime the stricture which occurred in the sigmoid flexure effectually prevented it. With regard to the saving of time, this came in, in the fact that in the purse string suture, there were not more than a dozen needle punctures to be made. The only suture that required to be accurate was that which brought the two folds of the mesentery together. This certainly saved time over the ordinary suturing method, where the needle had to be entered four or five times as often. Referring to the first case, he said the sequence of events was as follows: (1) A perfectly healthy man taken with diarrhoea; (2) following this was constipation, with evidence of obstruction, of pain, and of hæmorrhage. At the first operation it was found that the obstruction existed in the small intestine, loops of which had been destroyed by a destructive ulceration. At this time there existed no obstruction in the descending colon or rectum, and after the disease of the small bowel had been removed, perfectly formed stools were passed regularly, showing the functions of the intestinal tract to be normal. Now, the interesting part of the problem is, how all this trouble could have developed. Dr. Bell's idea was that it must have originated in the peritoneum over the brim of the pelvis, and that it afterwards extended to the bowel. From a mechanical point of view this seemed the most probable sequence of invasion.

*Spitting on Floors.*—The following resolution was moved by Dr. MILLS, seconded by Dr. MCCONNELL, and carried unanimously:

Inasmuch as spitting on floors is a practice not only filthy but dangerous to health.

It is hereby resolved, to urge upon the Montreal Street Railway Company the desirability of prohibiting spitting on the floors of their cars by notices posted prominently.

*Discussion on the Management of the Third Stage of Labor.*—Dr. J. C. CAMERON opened the discussion. The third stage of labor being the separation and expulsion of the placenta and membranes, it became necessary to enquire, what were the placenta and membranes? to what were they attached, and how were they attached? He described briefly the decidual lining of the uterine cavity which prepared for the reception of the impregnated ovum; the arrival of that ovum, with its chorionic covering, planting itself in the portion of the decidua, afterwards called serotina, and the development of the decidua reflexa; the part taken by the decidua in the formation of the placenta; the formation of the amniotic sac; the growth of the ovum until it finally fills the whole uterine cavity, and unites the decidua reflexa with the decidua vera, or original decidual lining of the uterine wall. The membranes then were three-fold, and together they form a tripartite bag which is filled with fluid in which floats the embryo. Considering the character and texture of the separate membranes, and taking them in the order of their occurrence commencing from the inside, he said the (1) amnion was elastic and strong; (2) the chorion was thicker and more friable, and connected very intimately with the (3) decidua which was composed of two layers,—an internal dense and firm, an external of a more spongy character. Summing up the character of the membranes as to strength, the latter decreases from within outward; the amnion very strong, the chorion less so, the decidua, being least of all, has very little cohesion.

When labor is about to begin, the uterus is an ovoid body, with walls of tolerably equal consistence, except at the lower part where the body joins the cervix. About one-fifth of its cavity is lined with placenta, and the remaining four-fifths with the membranes. The cervix at this time is completely closed, but with the onset of pains, the bag of waters is forced down upon the internal os, and gradually opens up the cervix by a process of bulging. In order to bulge and dilate the cervix, the membranes must separate from their uterine attachments; during the first stage we find that they are separated from the lower uterine segment. At the beginning of the second stage they rupture, and there is no further separation of the membranes till after the birth of the child. At the beginning of the third stage we find the uterus reduced considerably in size, and differentiated into two parts, an upper thick-walled contractile part, a lower thin-walled dilatable part; the function of the first is to contract, and expel the placenta; of the second, to expand, and give passage to it. There is no foundation for the statement that the placenta begins to separate normally when the head is being born. How then does the separation take place? Let us first recall how the different membranes are joined together. The amnion is loosely at-

tached to the chorion; the chorion is intimately connected with the decidua; and the decidua is attached to the uterine wall in pretty much the same manner as the mucous membrane is attached to the non-pregnant uterus. Having then very firm union between the chorion and decidua, and a more feeble union between the chorion and amnion, and between the decidua and the uterine wall, it is only natural to expect that the lines of cleavage, or separation of the membranes, would be either between the amnion and chorion or between the decidua and uterine wall. The latter is where separation usually takes place. What is the mechanism of the separation of placenta and membranes from the uterine wall? Various factors are concerned: (1) the contraction of the uterus; (2) the retraction of the uterus; (3) the effusion of blood. Dr. Cameron then dwelt upon the two theories which were put forward to explain the expulsion of the placenta. The one claimed that the contractions of the uterus during labor caused the placenta to arch or bulge downwards into the uterine cavity, causing a partial separation from the uterus with effusion of blood into the concavity of the arch, between the placenta and uterus. The pouring out of this blood caused by its pressure a still further increase of the arching process, until finally the whole placenta separated and descended with its foetal aspect presenting. The other theory was that rupture of vessels played no part in the separation and expulsion, which were solely the result of the contraction and retraction of the uterus. The speaker thought both explanations were right in certain cases, the situation of the placenta as well as its extent determining the mechanism of separation and expulsion. When the uterine wall contracts, the placenta contracts also, it moves with, but not to the same extent as, the uterus. The placenta can be diminished in area by contraction about one-half on the average. Having reached the limit of its reduction in size, it remains rigid, while the uterus goes on contracting, and draws itself off from the placenta. Some authors believe this separation begins in the centre, some at the side. It was then explained how it may occur in either way. In studying the mechanism of separation, it is important to remember that the whole uterus contracts, not the placenta only, so that not only does the placental surface decrease in size, but the whole uterus contracts and grasps it on all sides. The method of separation depends largely upon whether the uterus contracts upon the placenta evenly all around, or whether the contraction is irregular; and upon whether the placenta is uniformly adherent to the uterus or has some points at which it is more firmly adherent than others. Irregular uterine action and abnormal or pathological attachment of the placenta modify the mechanism of the separation and expulsion of the placenta.

Another point to be borne in mind is that there is not normally a true uterine cavity into which the placenta may bulge. As soon as the child is born, the uterus contracts and the anterior wall comes against the posterior wall. It is this absence of an actual cavity which makes the theory of the arching of the placenta untenable in most cases; sometimes when it is situated directly over the fundus, its central portion may bulge down towards the os which is the point of least resistance. But if the placenta is situated upon the side of the uterus, arching does not take place, but the lower edge glides downwards and presents at the os. Coming then to the separation and expulsion of the membranes, it will be remembered that the portion over the lower uterine segment was separated during the first stage; the rest which constitutes about four-fifths of the whole is attached. The membranes are separated (1) by retraction of the uterus during the second stage and the beginning of the third stage. As the uterus is emptied, it retracts by drawing the uterine wall together; the membranes are thus thrown into wavy folds which are most marked close to the uterine surface or in the decidual layer. The crest of each of these folds in the decidua tends to separate from the uterine wall, and a little hæmorrhage follows, which still further separates the membranes. This, however, is only capable of carrying the separation a certain distance, and the process has to be completed by the traction of the placenta which drags the membranes after it as it descends.

We have here a fair statement of the problem before us. The mechanism varies according to where the placenta is situated on the uterine wall, its extent, the existence of pathological adhesions, the uniformity of uterine contraction, the relative strength of the union between amnion and chorion as compared with that between chorion, decidua and uterine wall.

In concluding his introduction, Dr. Cameron hoped the discussion would be narrowed down to the two following questions: (1) Are drugs of any value, do they help us in the management of the third stage of labor; if so, what are they? What are their indications and contra-indications? (2) Are manipulations of service; if so, what manipulations and when are they of use? What are their indications and their contra-indications?

Dr. H. L. REDDY then took up the drugs used in the third stage of labor; his paper on the subject was as follows:—

The part assigned to me in to-night's discussion is the use of drugs, or rather the drugs used, in the third stage of labor.

I find that it is impossible to limit myself to the third stage in some cases; as, for example, chloroform, which is so commonly used in the second stage, and so frequently produces un-

pleasant effects in the third. Therefore, I hope you will pardon me if I take up your time, to some extent, in considering these drugs outside the stage under discussion.

I have endeavored to give the opinions of standard authorities, and have also taken the trouble to write to a number of the leading obstetricians in the United States, more particularly with regard to the use of ergot and chloroform, and have received replies to all of my enquiries. This, I think, will perhaps make what I have to say slightly more interesting.

The time allotted to me is, I am sorry to say, entirely too short to give more than a short résumé of the subject. I, therefore, have only taken up for consideration the most commonly used drugs.

#### ANÆSTHETICS.

Firstly, what is the indication for them?

- Relief of pain;
- Relaxation of parts;
- Prevention of untimely movements.

In looking up the matter we find Donhöff, in the Archives for Gynæcology, shows the influence of chloroform upon the course of normal labor by the tachodynamometer to be as follows:

The administration of chloroform, even in diminutive doses, exercises a retarding influence upon the progress of labor. Time prevents us taking up his experiments fully.

Playfair, the English standard authority, says:

"The tendency of the present day is to give too much anæsthetic during child-birth, and a common error is the administration of chloroform to an extent which materially interferes with uterine contractions, and predisposes to postpartum hæmorrhage. In considering anæsthesia in the third stage, or the effects produced in the third stage, the subject would not be complete without referring to its use in the earlier stage of labor. Generally speaking, we do not think of giving chloroform until the os is fully dilated, the head descending, and the pains becoming propulsive. It has often been administered earlier, in order to aid in the dilatation of a rigid cervix, and while it may succeed well, chloral answers the purpose better. There is one cardinal rule to be observed: in giving chloroform during the propulsive stage, it should be administered intermittently and not continuously. When the pain comes on, a few drops may be scattered over a Skinner's inhaler. During the acme of the pain the patient inhales it freely, and at once experiences a sense of great relief. As soon as the pain dies away the inhaler should be removed. Indeed, if properly given, consciousness should not be entirely abolished, and the patient between the pains should be able to speak and understand what is said to her, or,

in other words, the chloroform should be administered to the obstetric and not to the surgical or profound insensibility, except, perhaps, just at the moment the head is passing over the perineum. The effect of the chloroform on the pains must be carefully watched. If they become materially lessened in force and frequency, it is necessary to stop the inhalation for a short time, until the pains get stronger. This effect may be often completely and easily prevented by using Dr. Sanson's mixture, one-third absolute alcohol and two-thirds chloroform, this diminishing the tendency to undue relaxation. Bearing in mind the tendency of chloroform to produce uterine relaxation, more than ordinary precautions should always be taken against postpartum hæmorrhage, in all cases in which it has freely been administered. In cases of operative midwifery, it is usually given to the extent of complete anæsthesia, and in all such cases it should be given by another medical man, not by the operator."

Winkel believes that chloroform should not be used in all obstetrical operations, unless they are of a difficult nature, and believes the best method even here in order to avoid difficulties is to carry the anæsthesia only so far that the patient feels the pains at the completion of the operation and awakens with the crying of the child.

Dr. E. Montgomery, Philadelphia, makes it a rule to give an anæsthetic to every patient during the second stage of labor. The anæsthetic he uses is the bromide of methyl, which has the advantage over ether and chloroform that it acts quickly and its effects pass off quickly, thus producing less influence than either ether or chloroform. It is not necessary that the patient should be brought so profoundly under its influence as is necessary under chloroform. He says: "I have never found it to have any unpleasant influence upon the third stage of labor, as is claimed to arise from the use of chloroform."

Dr. Parvin uses anæsthetics possibly in one-third of his cases, usually ether. He finds that it blunts the sharp edge of the pain, the patient bears down better, and it lessens the resistance of the soft parts. He believes that it neither induces hæmorrhage nor delays uterine contraction if given in moderate quantities, so as only to produce obstetrical, not surgical, anæsthesia. For prolonged operations he uses ether always.

Dr. H. J. Garriges, of New York, uses anæsthetics in every case in the second stage of labor, unless the patient objects,—generally chloroform. He considers that it is apt to invite want of contraction and hemorrhage. He considers ether safer if the kidneys, lungs and brain are healthy.

Dr. Wm. Polk does not use anæsthetics if he can evade it, and then only at the close of labor, never in pathological cases. He con-

siders, outside of the relief of pain, the effect is a bad one, as it both induces hæmorrhage and delays uterine contraction in the third stage.

Dr. E. H. Grandin as a rule uses an anæsthetic when the presenting part reaches the pelvic floor, always in primiparæ. He uses chloroform, except in cardiac cases, and then ether. He finds that it produces relaxation of uterine spasms and of spasm of the muscles and fascia of the pelvic diaphragm. "If the anæsthesia be prolonged," he says, "I am on the lookout for excessive hæmorrhage and delayed uterine contraction." He uses chloroform in prolonged operations when a careful anæsthetist gives it, otherwise he uses ether.

Dr. Reynolds uses anæsthetics in the second stage of labor when the contractions are good. He finds the action to be relaxation of the os and the muscles of the perineum, with diminution of the force of labor, in slow cases this latter being one of the disadvantages of the use of the drug. He says he generally carries ether to the point of unconsciousness so soon as he can control the chin per rectum, in the belief that he can more often by this method save the perineum. He believes that the use of an anæsthetic in the second stage causes an increase in the relaxation of the uterus and consequent hæmorrhage. He has never had a fatal case of post-partum hæmorrhage. He uses ether entirely, because the opinion of the community in which he lives is against the use of chloroform.

Dr. Clifton Edgar does not use anæsthetics as routine in the second stage of labor. When he does use an anæsthetic he uses the A. C. E. mixture, sometimes sulphuric ether. He finds that it relaxes a rigid cervix, often rendering the subsequent pains more efficient. Chloroform, he finds, is likely to produce both hæmorrhage and delay in uterine contraction when used in excess. In prolonged operations he uses ether, and his chief objection to chloroform is that one not thoroughly familiar with its administration will abuse its use by giving too much.

Dr. Charles M. Green almost always uses anæsthetics in the second stage of labor and uses Squib's sulphuric ether. He finds the effect produced to be a relaxation of the soft parts, better success in saving the perineum from laceration, both on account of relaxation and because he has complete control of the patient. Personally he has had no bad effects, but believes that long continued anæsthesia does predispose to uterine inertia and hæmorrhage. In prolonged operations he states that all the Boston men use ether to the exclusion of chloroform, his chief objection to chloroform being that it is more dangerous to administer.

Dr. E. P. Davis uses anæsthesia in nine cases out of ten, usually chloroform for normal cases and version, for all the other operations ether.

He finds that it produces better uterine contraction by removing the cerebral inhibition from conscious suffering, partial relaxation of the uterus when pushed, facilitating manipulation. He believes that chloroform when properly used produces neither hæmorrhage nor delayed uterine contractions in the third stage.

It is generally agreed that the operator must always begin the anæsthesia if no skilled assistant is present. After anæsthesia has been begun, the nurse may hold the inhaler, although the physician must himself pour on the fresh chloroform if needed. For the want of following this rule I have known of a fatal case happening. In chloroform narcosis the contraindications are cases of anæmia in the dying, well-marked goitre, in myocarditis, in cases of dyspnœa or extreme collapse, heart disease, or placenta prævia.

To sum up, with regard to anæsthetics, in this country and the United States the majority of practitioners seem rather to favor its use, although in England and abroad they do not recommend its use to nearly the same extent, and almost every one of the authorities consulted agree that it undoubtedly predisposes to uterine inertia and consequent hæmorrhage in the third stage. This more particularly applies to chloroform, which is most commonly used. Anæsthetics are hardly ever used in the third stage, unless in cases of severe operative procedure.

Dr. J. C. Reeves, of Dayton, Ohio, one of the best authorities on chloroform in the United States, and author of the chapter on the subject in the *American System of Obstetrics*, Vol. I., uses chloroform frequently whenever the pain is severe or the soft parts give slowly. He says he believes that it has an injurious effect likely to be marked in proportion to the length of time used and the depth of narcotism. He expects to watch a patient more closely after anæsthetics.

Dr. George L. Engelmann, of St. Louis, uses anæsthetics moderately in the second stage of labor, always chloroform, depending upon the sensitiveness and nervousness of the patient and relation of the pelvis to the head. He finds the effects vary with the case, pains more regular, powerful and efficient in many cases, especially in nervous women. He believes no ill effects arise in the third stage, unless overdone, and care is necessary.

Caseaux finds that chloroform is of service both in relieving pain and causing relaxation of the parts, but predisposes in the third stage to uterine inertia and p.p. hæmorrhage.

Such, I may say, is my personal experience both in private and hospital work. I consider towards the end of the second stage, where the pain is very severe, it is apt to cause inversion of polarity, thus delaying labor and con-

sequently unnecessary suffering, therefore an anæsthetic should be given, and its use when the head is stretching the perineum will very often save it from rupture. But to give it beyond the obstetrical degree and for long periods is not only unnecessary, but absolutely bad practice.

#### ERGOT.

We will next consider ergot, one of the most common drugs used in the third stage.

Playfair believes that it is thoroughly good practice to administer a full dose of the liquid extract of ergot in all cases after the placenta has been expelled, to insure persistent contraction and to lessen the chance of blood clots being retained in utero. He prefers, as a rule, personally to give a subcutaneous injection of ergotine in cases where there is a history in previous labors of hæmorrhage after the birth of the child, when the presentation is so far advanced that we estimate that the labor will be concluded in from ten to twenty minutes, as we can hardly expect the drug to produce any effect in less time. In cases of post partum hæmorrhage the dose may be repeated, but here the hypodermic use of ergotine offers the double advantage of acting with greater power and much more rapidly than the usual method of administration. It should therefore be always used in preference.

Chahbazain, of Paris, recommends an aqueous solution of ergotine the one two-hundredth of a grain in ten minims of water as acting more energetically.

Dr. Engelmann, of St. Louis, says in obstetric practice it does good service if given after the contents of the uterus have been expelled, to stimulate contraction when labor is completed, and as a safeguard, especially after the physician has left his patient.

Dr. J. C. Reeves, of Dayton, Ohio, does not use ergot as routine practice, but when he does give it, it is only after the expulsion of the child, in doses of one fluid drachm. He finds that irregular contraction of the uterus is caused, imprisoning the placenta very frequently after its administration.

Dr. Norris, of Pennsylvania, recommends in every case the administering of one drachm of fluid extract of ergot in the treatment of the third stage.

Dr. H. Grandin, of New York, uses ergot as routine practice in obstetrics, after the uterus has been thoroughly emptied, and finds that its routine use prevents undue relaxation and appears to promote proper involution. He uses a half to one drachm of fluid extract of ergot for three days, and then twenty drops three times a day for a week.

Dr. Wm. M. Polk, of New York, does not use it as routine, but when he does give it, it is always after the second stage of labor and he

finds that it produces uterine contraction. He uses one drachm of the fluid extract.

Dr. Edward Reynolds, of Boston, uses ergot as routine practice, never before the delivery of the placenta, and finds that it hastens the occurrence of tonic contractions, and thus lessens the likelihood of post partum hæmorrhage. He uses the fluid extract, Squib's, one drachm.

Porro recommends ergot in cases of hæmorrhage, or where hæmorrhage is likely to occur.

Dr. Marx, of New York, in large hospital experience, has in nearly every case given ergot by mouth, at or toward the end of the second stage of labor, and has never seen a bad result from its use, certainly never a case of accidental hæmorrhage. He finds that there is no better remedy to regulate the pains of labor than ergot. Possibly large doses of quinine, but this remedy does not increase the frequency of pains as much as it increases their vigor. It is impossible to wait for the administration of ergot until the uterus is absolutely empty, for then it would never be given, as there are always shreds of decidua and blood.

Dr. Nash, of Washington, does not approve of the administration of ergot after the placenta has been delivered, or that of promoting the process of involution by the daily display of ergot, digitalis and quinine, as is suggested in practice in some institutions.

Reynolds, in his work on midwifery, declares the efficiency of ergot in producing tonic retraction of the recently delivered uterus is undoubted, and since its use is productive of no possible harm, it is the usual custom, and the author believes should be the habit, of all obstetricians, to administer to the patient a teaspoonful of the extract immediately after the birth of the placenta. This is to be recommended as a routine procedure, because the action of ergot is too slow to render it of value if its administration is delayed until after the occurrence of hæmorrhage, unless it is given hypodermically, a procedure which it is wise to avoid, in view of the fact that the hypodermic use of ergot is not unfrequently followed by subcutaneous abscess. If it is so used, it should be deeply injected into the substance of the thigh, as this method decidedly diminishes the risk of subsequent suppuration. The use of ergot by the mouth is occasionally followed by nausea, which is, however, rare, if no more than a drachm of the fluid extract is given in about two ounces of cold water.

Dr. Clifton Edgar does not use ergot as routine practice, but if given, always after the third stage. He finds it produces good uterine contractions, and possibly the prevention of after-pains. He gives one drachm of fluid extract at a dose.

Dr. Charles M. Green, of Boston, uses ergot as routine practice, after the delivery of the



placenta, never before, and finds that it promotes the contraction and retraction of the uterus and thus helps to prevent hæmorrhage. He generally uses a drachm of the fluid extract at a dose. He considers that grasping the fundus after the use of ergot causes a succession of rhythmical contractions and consequent retraction, which latter action permanently closes the uterine sinuses.

Dr. E. P. Davis, of Philadelphia, does not use ergot as routine practice, but only when the uterus fails to properly contract and remain contracted. He finds the effect produced to be that it promotes uterine contraction and furthers involution, and when given in small doses after the third stage it increases blood pressure in the breast and furthers the secretion of milk. He uses the fluid extract in doses of from one drachm to ten minims.

Dr. Parvin, of Philadelphia, does not use ergot as routine practice in obstetrics. He occasionally gives it in the second stage of labor in small doses when the contractions are weak. After the delivery of the placenta, if the uterus fails to contract sufficiently, he gives from half to a teaspoonful of the fluid extract to provide against hæmorrhage. He finds that there is an increase of force in intermittent contractions from small doses, continuous action from large. In some cases he finds no beneficial results at all.

According to Wernich, ergotine lessens the tension of the veins and increases their dilatation. This produces arterial anæmia of the uterus and its nerve centres, which increases the duration and intensity of its contraction; after strong doses the intervals cease altogether and a condition very like tetanus uteri sets in.

According to Kobert, this action is due to sphaelic acid contained in ergot, while the ergotinic acid has no effect on the uterus whether gravid or not. The third constituent part of ergot, cornutin, a pure alkaloid, was, according to Grafe's and Erhard's experiments, given repeatedly in the first stage of labor in doses of 5 mg., and in nearly two-thirds of the cases improved the pain and did the mother no harm.

Schatz declares that the action of ergot begins fifteen minutes after its administration by the mouth, is greatest in thirty minutes, and the effects of a single dose last for an hour.

Winkel says its use in placenta prævia, before and during labor, is still sub judice. Auvard used it with unsatisfactory results, mortality being 42 per cent. of the mothers and 77 per cent. of the children. On the other hand, Wilson had a mortality of 6.6 per cent. of the mothers and 26.6 per cent. of the children, using it before labor.

Counter-indications, I know of none, unless it be its administration during the progress of the first and second stages of labor, or in cases of known idiosyncrasy, where it causes severe

and exceedingly painful tonic contractions, amounting almost to tetanus uteri.

Caseaux recommends ergot for use in the third stage, as causing firm uterine contraction, promoting involution and tending to prevent hæmorrhage.

To sum up with regard to ergot, it is used by the great majority of practitioners, as well as recommended by the standard authors at home and abroad. They nearly all agree that it undoubtedly produces firm contraction of the uterus at the completion of the third stage, if given in doses of one fluid drachm, grasping the fundus, assisting in keeping up not only the contraction but the polarity of the uterus, and inasmuch as it takes 15 to 20 minutes to act, it had better be given immediately on the completion of the second stage. None of them speak of any bad effects resulting from its use, and I fail to see why any sensible practitioner should refuse or object to its use. My own practice certainly is, both in private and in the hospital, to give one fluid drachm at the conclusion of the second stage, and in the hospital I give for the following week ten drops of the fluid extract three times a day, combined with both digitalis and quinine. This latter, I believe, both tends to close the sinuses and regions from which infection might occur, and to promote involution as well as slightly to increase the blood pressure. The latter I consider to be a distinct advantage.

#### STYPTICS.

Dr. Playfair states that in severe cases where the uterus obstinately refuses to contract in spite of all our efforts—and do what we may, cases of this kind will occur—the only other agent at our command is the application of a powerful styptic to the bleeding surface to produce thrombosis of the vessels. The latter, says Dr. Ferguson in his preface to Gooch on Diseases of Women, appears to be the sole means of safety in those cases of intense flooding in which the uterus flaps about in the hand like a wet towel. Incapable of contraction for hours, yet ceasing to ooze out a drop of blood, there is nothing apparently between life and death but a few soft coagula plugging up the sinuses. These form but a frail barrier indeed, but the experience of all who have used the injection of a solution of perchloride of iron in such cases proves that it is thoroughly effectual, and its introduction into practice is one of the greatest improvements in modern midwifery. The dangers of the practice have been strongly insisted on, but there are only one or two cases on record followed by any evil effects. Its extraordinary power of instantly checking the most formidable hæmorrhages is well known to all who have tried it. Indeed, Playfair goes so far as to say that no practitioner should attend a case of midwifery without having his styptic

with him, and the best and most easily obtainable form is the liquor ferri perchloridi fortior of the B.P., and should be used diluted with six times the bulk of water. It is important that the air should be got rid of out of the syringe with which it is introduced into the uterus, and to get the best effect the uterus should be emptied of all clots, etc., before its use. After its use for some days, intra-uterine injections should be used to remove the coagula which are certain to form, and thus avoid saphræmia.

Winkel says, in severe cases of hæmorrhage where other means have been tried and failed, equal parts of the liquor ferri perchloridi and water may be slowly injected into the uterus with good effect, or it may be applied by means of a sponge or piece of absorbent cotton to the site of the hæmorrhage.

Reynolds, of Boston, recommends that in severe cases of hæmorrhage, Monsell's solution or liquor ferri persulphatis diluted with four times its quantity of water should be passed into the uterine cavity on a ball of absorbent cotton, the uterus being first cleared of all clots.

Dr. Norris, of Pennsylvania, considers that styptic salts of iron are dangerous, as the coagula produced by them may extend into the vessels, and must be broken up by putrefaction, exposing the patient to septic poison.

To sum up with regard to the use of iron in postpartum hæmorrhage, several of the standard authorities, such as Playfair, Winkel, etc., recommend its use as being the only remedy that is invariably successful. My own experience has been most favorable to the use of iron, and in the Women's Hospital, as well as in private practice, the invariable rule is in all cases of alarming hæmorrhage, to use liquor ferri perchloridi diluted with from six to ten times its bulk of water. I have never had an accident during or after its use; the results have been invariably gratifying. A common objection has been raised, and that is air being injected into the vessels. I fail to see that it is any more likely to be injected with the iron solution than with any other injection, although one could perhaps understand air being imprisoned in clots, but this perhaps is far fetched and harmless. I think the chief danger, if not the only one, that is the clots which form in the uterus are firm and do not easily come away, and are apt to set up saphræmia, unless they are washed away by intra-uterine douches given at least twice daily. Another danger might perhaps be if the end of the nozzle were applied directly to a sinus, the solution might be pumped directly into the circulation. I can find a record of but three fatal cases from its use, two mentioned by Playfair and one witnessed by Dr. J. C. Cameron at the Rotunda, Dublin.

Noeggerath recommends tincture of iodine, 1 to 5 of water.

Dupierries 30 water, 15 tincture of iodine, potassium iodide 5. These do not seem to be greatly used, though they doubtless act as styptics.

Reynolds refers to tincture of iodine being used preferably to Churchill's, and states the advantage of iodine over the iron solution is its more stimulating character, and the lesser liability of causing an extensive thrombosis formation and a consequently increased danger of septic infection.

Penrose strongly recommends strong vinegar, which has the advantage of being always readily obtainable. He speaks highly of its hæmostatic effect. He soaks a clean handkerchief in it and introduces it by the hand into the uterine cavity, and squeezes it over the endometrium. He says the effect of the vinegar flowing over the sides of the cavity of the uterus and vagina is magical. The relaxed and flabby uterine muscle instantly responds, the organ assumes what is called its gizzard-like feel, shrinking down upon and compressing the operating hand, and in the vast majority of cases the hæmorrhage ceases instantly.

Playfair remarks that it might be worth trying before using the iron solution.

Reynolds advises a 1 to 100 hot water solution of the officinal acetic acid as a prompt styptic.

Creolin if added, even in the quantity of a few drops, to the hot water injections used in post-partum hæmorrhage, acts as a powerful styptic as well as a good antiseptic; or carbolic acid may be added to the hot douche about the strength of 1 to 40 or 80, and would be found to act as a hæmostatic by its stimulating contraction of the uterus.

#### DISINFECTANTS.

The use of disinfectants in the third stage is at present a vexed question, and the use of douching either before labor or after labor, unless for cause such as a severe leucorrhœa or one that is suspected of being infected by gonococci, is at present rather condemned than advised. In one of last numbers of the *Archives for Gynecology* are statistics very unfavorable to it. Probably the most commonly used disinfectant is corrosive sublimate.

Winkel says the use of corrosive sublimate for irrigating the uterus is to be avoided, as poisoning is liable to supervene; but if used, a 1 to 5000th corrosive sublimate solution at a temperature of about 110 to 115° F., that is, at that which is distinctly but not uncomfortably hot for the hand.

Playfair says that a solution of 1 in 2000th solution of perchloride of mercury may be used, if needed, to diminish the danger of saphræmia.

Reynolds recommends a 1 to 5000th corrosive sublimate solution at a temperature of 110 to 115° F.

Dr. Howard Kelly writes: "The best disinfectant in puerperal cases is pure warm water. The trouble of all drugs applied intra-uterine is that they only reach the less superficial area, and if there are any foci of infection, the germs which lie deep in the tissues are neither destroyed nor removed. For this reason I consider the mechanical means, with pure and free drainage, the best. The bichloride of mercury I consider dangerous and inefficient, and ought never to be used under any circumstances intra-uterine."

Dr. Norris, of Pennsylvania, says the bichloride of mercury is effective but dangerous. Creolin is as powerful and safer, and is therefore to be recommended.

My own experience of the use of corrosive sublimate post-partum, in similar and even weaker solutions, is most unfavorable, although followed by large douches of warm water, which but few authors recommend to be used. In a solution strong enough to be of service, most authors agree it is dangerous to use intra-uterine, and it ranks no higher in the comparative table than does creolin and probably strong solution of permanganate of potash. Therefore it ought to be discarded, except for external use.

Ice and iced water are recommended by many authors to be used in cases of p.p. hæmorrhage, the ice introduced to be not larger than a walnut. There are several objections, I think, to its use: it increases the shock already existing, although it undoubtedly checks the hæmorrhage for the time being, and as soon as it melts or is removed, the hæmorrhage often returns as severely as before, the uterine vessels which it contracted now dilating. Great care would also have to be used that no sharp, irregular pieces were introduced, as the contraction produced by the ice might possibly drive the sharp points through the uterus. In winter in this country some practitioners make a hard snowball and introduce it, thus avoiding the danger of perforation.

Hot water is probably the most commonly used and best means for checking p.p. hæmorrhage at a temperature of from  $110^{\circ}$  to  $128.75^{\circ}$  F., this latter temperature being, in my opinion, much too warm, being decidedly uncomfortable to the hand. The water should have been boiled and been allowed to cool. It has the advantage of being always obtainable, of, as a rule, stopping the hæmorrhage, and of allowing afterwards some other means to be used if desired. The quantity to be used should be at least from one quart to half a gallon, and if given by a douche bag held sufficiently high, at least six or seven feet, will not only check hæmorrhage, but also remove the debris from the uterus. One point about giving the hot douche is that a metallic nozzle should never be used, preferably a perfectly aseptic German glass tube.

The question may be asked: what would you consider a dangerous hæmorrhage? This is only a relative term, for what to one would be but a slight hæmorrhage might to another, or to the same under certain conditions, be a dangerous hæmorrhage. Generally speaking, a slight hæmorrhage would be from 500 to 1,000 gms. of blood lost, a profuse hæmorrhage from 1,000 to 1,500 gms., and a dangerous from 1,500 to 2,000 gms.

#### STIMULANTS.

Amongst the stimulants used in p.p. hæmorrhage, probably none will be found to act more promptly or satisfactorily than the nitrate of strychnia, in doses of from one-fortieth to one-twentieth of a grain hypodermically, within a very short period the pulse rate becoming much slower and fuller.

Opium in cases of hæmorrhage is highly recommended by many of the authors, and seems to have a direct action as a stimulant upon the heart. It is best given in the form of a hypodermic of Battley.

Brandy or ether are used hypodermically, either after severe hæmorrhage with heart failure, or heart failure from any cause in the third stage or immediately after it. It is given hypodermically in half drachm doses, repeated as often as needed. Most authorities recommend its use.

A solution of chloride of sodium, although seldom used directly in the third stage, may be needed, and is a most excellent remedy immediately after severe cases of hæmorrhage, whether post-partum or in cases of placenta prævia. Its use is found in supplying fluid to the arterial system depleted by the hæmorrhage, and perhaps preventing too great absorption of noxious fluids. It may be best administered in the strength of a dessert-spoonful and a half to a quart of tepid water, and allowed to trickle into the rectum from the douche bag placed at about the level of the anus, the attendant every half hour lifting the bag and allowing a small quantity to enter. As much as a gallon and a half may thus be given and absorbed in thirty-six hours, the effect on the pulse being most gratifying, being not so compressible and much more full. The advantage of the solution of sodium is that it is readily absorbed by the rectum.

In conclusion, I beg to thank you, gentlemen, for the patience with which you have listened to me. The brief which I have held for the use of drugs in the third stage I have endeavored to defend, and I hope to convince any sceptics, if it be possible there are such, that drugs are not only useful, but on occasions absolutely required, and anyone not using them places himself against the weight of authority in the medical world.

Dr. A. A. BROWNE took up the manipula-

tive processes which might be required in management of the third stage. These were: (1) Manual expression of the placenta by the hand externally, and (2) removal of retained placenta by the hand in utero. He thought that after the child was born and the cord tied, gentle pressure should be made, the uterus followed down as it contracted, while the patient was allowed to rest and the placenta to become separated. In an absolutely normal labor the uterus would expel the placenta without further assistance in from 15 to 20 minutes; if it did not, expression was done probably best by the method of Credé. This is carried out in the following manner: The uterus should be grasped in the hollow of the left hand, the ulnar edge being well pressed down behind the fundus, and when it was felt to harden, strong and firm pressure should be made downward and backwards in the axis of the pelvic brim. If the first attempt were unsuccessful, the manœuvre should be repeated at the next contraction, and on a second failure a vaginal examination made, and the placenta, if found lying wholly in the vagina, withdrawn. If, however, it were still in the uterine cavity, he would again attempt to expel it by pressure and not by traction on the cord. The membranes were best removed by twisting and gentle traction.

Dr. Browne divided retained placenta into two kinds: (1) Simple and (2) where due to morbid adhesions. The former might be caused by inertia, large size of the placenta, hour-glass contraction, traction on the cord, or ergot. The latter was due to endometritis before or metritis or placentitis during pregnancy.

He recommended introducing the hand into the uterus with strict antiseptic precautions, and separating the placenta gently with the ulnar side of the hand, making a to and fro motion, the back of the hand being towards the uterine wall. On any portions not coming away, they might be peeled off by using the finger nail as a curette, but in many cases it was quite impossible to get all removed without using undue violence. Then it was better to give intra-uterine douches of hydrargyrum perchloride, followed by carbolic or creolin, and allow it to come away by necrosis.

In conclusion, Dr. Browne spoke very strongly against the following methods of removing the placenta:—1. Dragging on the cord. 2. Forcible dragging out of the placenta by the hand in utero.

Dr. F. W. CAMPBELL, even after hearing the previous speakers, believed that his own experience of 32 years was as reliable as any knowledge he could acquire from the text-books of to-day. He thought that the uterus itself by contraction and retraction expelled the placenta, and had often found a cough or

the application of a binder very useful. He desired to enter the strongest possible protest against the modern practice of employing chloroform. A few drops on a towel sufficient to partially stupify might be an advantage, but few women would be content with this, and very little more produced unconsciousness, with entire cessation of uterine contractions. Moreover, he believed it to be invariably followed by a tendency to hæmorrhage, and he never gave it except when compelled to do so, and then only when the head had been pressing on the perineum for some little time. Quinine in full doses decidedly increased uterine contractions. As styptics, he preferred vinegar, ice, or hot water. With regard to the expulsion of the placenta, ten minutes he thought had been the average in his own cases, where he used manipulation, and traction when the placenta was in the vagina. He quoted Sir James Simpson's rules. Dr. Campbell separated an adherent placenta with the front of the hand towards the uterus instead of the reverse, as recommended by Dr. A. A. Browne.

Dr. G. A. BROWN used chloroform in the vast majority of his cases in the latter part of the second stage. It was contra-indicated in those who were anæmic, who suffered from chronic uterine trouble, and who had weak pains and flabby tissues, as then it was apt to be followed by hæmorrhage after the expulsion of the placenta. He was inclined to think that during the third stage, ether given by means of the Clover inhaler was preferable. Owing to the time necessary for the absorption, he now gave ergot immediately after the birth of the child instead of at the end of the third stage, and cited three cases in which a post-partum hæmorrhage, occurring with the latter method in previous labors, had been prevented at subsequent ones. He believed that if the accoucheur took the precaution of completely emptying the uterus, styptics could be to a great degree dispensed with; when necessary, he used hot water or the insertion of a piece of alum. He strongly objected to perchloride of iron, as it greatly increased the danger of sepsis. As a stimulant after excessive hæmorrhage, he used strychn. nitrate gr. 1-60 hypodermically. He considered Credé's the only scientific method for expulsion of the placenta, and in cases of retention followed the plan adopted by Dr. A. A. Browne.

#### ACADEMIE DE MEDECINE.

SUDDEN DEATH ON THE BICYCLE.—M. L. H. Petit reported three cases of sudden death following the use of the bicycle, all in persons suffering from a cardiac affection. The first case was that of man 60 years, robust in physique, who had practised with his teacher.

for a month, and who, during a lesson, feeling indisposed, called the teacher and died in his arms. The second case was that of a physician, who wished to reduce his size by bicycle-riding. He had never had any cardiac trouble. At the end of several months he was attacked with dyspnoea and excessive pain in the heart. He descended from his machine, seated himself on a bench, and died shortly after. The third case was that of a clubman, about 40 years old, who died on his bicycle on one of the streets of Paris. He also had a cardiac affection.

From the 1st of January to the 27th of August, the Prefecture of Police issued 32,996 permits for the use of the bicycle. As many persons do not apply for permits until compelled to do so, it may be said that there are about 100,000 persons in Paris who use the velocipede. It is probably not an exaggeration to estimate that of this number 1 in each 1000 suffers from some cardiac trouble, and it is therefore well to call attention to the risks which they run in this sport.

Old age in itself, according to M. Petit, should be regarded as a contraindication, without any reference to heart disease. The use of the bicycle requires a suppleness, an attention, and an expense of strength which cannot be permitted to elderly persons without fear of bad results.—*Gazette des Hôpitaux*, September 11, 1894.

## Progress of Science.

### TREATMENT OF STRANGULATED HERNIA.

Dr. G. E. Wherry is of the opinion that all cases in which signs of strangulated hernia have existed for less than twenty-four hours should be relieved by coughing-taxis, especially in inguinal hernia previously reducible. If taxis fail, chloroform should be given and herniotomy performed, with an attempt at radical cure. In cases in which taxis is successful, an operation for radical cure should be advised before the return of the patient to an active life.—*Practitioner*, September, 1894.

### EFFECTS OF THYROID ADMINISTRATION.

In a paper upon myxoedema and thyroid extract, Dr. Geo. W. Crary, of New York, expresses the belief that many so-called idiots, imbeciles, cases of arrested development, etc., among children, are in fact cases of functional inactivity of the thyroid gland, and hence susceptible of treatment by thyroid extract, with improvement and perhaps even cure. He summarizes as follows the effects of thyroid

treatment: Increased metabolism, shown by: (1) elevation of temperature; (2) increased appetite, with more complete absorption of nitrogenous foods; (3) loss of weight, with nitrogen excreted in excess of that taken in the food; (4) growth of skeleton in the very young; (5) marked improvements in body nutrition generally; (6) increased activity of mucous membranes, skin, and kidneys. The rheumatic symptoms and the anæmia are not only not relieved, but are most frequently aggravated.—*American Journal of Medical Sciences*, May, 1894.

### DIAGNOSIS OF TUBERCULOSIS IN CHILDREN.

Dr. E. Weill, of Lyons, has observed a special syndrome in three cases of infantile pulmonary tuberculosis which he believes to have been as yet unnoted. It consists in a sensation of cold with perceptible lowering of the peripheral and central temperature, marked cyanosis of the extremities with noticeable modification of the radial pulse, considerable alteration of the number of red cells in the cyanosed portions and in the composition of the urine. These conditions are readily produced by having the patient leave his bed, and they slowly disappear when he lies down. They are transitory symptoms, of an intermittent character, independent of the clinical form of the tuberculosis, of the stage of the disease, of the season, or of the diet.—*Lyon Medical*, May 20, 1894.

### CHLORAL HYDRATE—SOME OF ITS USES.\*

By BEN. H. BRODNAX, M.D.,  
Of Brodnax, Louisiana.

In conversation with physicians at various times, I have noticed they viewed chloral as merely a hypnotic, and had used it only for the purpose of relieving pain, thereby inducing sleep. I have been a little surprised at this want of knowledge of its other equally valuable properties. Early in my practice I tried to make a few medicines, combined or by themselves, do all that they would for me, and was led into experimentation with them. Chloral came in for its share, because it relieved pain, quieted the nervous system, and did not paralyze the bowels.

As a *hypnotic*, five grains of chloral combined with laudanum or with one-eighth or one-quarter grain of morphine acts splendidly, the combination intensifying the effects of each and depriving the opiate of its stimulating property. With children, by itself, in sweetened water, it

\* Read before the Philadelphia County Medical Society, by Oscar H. Ellis, M.D., June 13, 1894.

has no equal; mixed with paregoric, it is also good.

I *prepare* it as follows: I just cover the amount in my case vial with glycerin—this dissolves it, and a drop is about a grain. In this form it mixes readily with oil or water and is more quickly prepared, and more easily divided into doses, large or small. With castor oil the dose one to five grains renders it less nauseating, and does not gripe, at the same time producing quiet and rest.

Applied to the skin in eruptive diseases—measles, urticaria—as follows: Chloral, 10 grains (drops); carbolic acid, 10 grains (drops); water or oil, 1 to 2 ounces, almost instant relief is experienced of the intense itchings. Or chloral, 10 drops; glycerin and water, each  $\frac{1}{2}$  ounce, produces the same effect.

As a mouth-wash: Chloral, 10 grains; glycerin and water, each  $\frac{1}{2}$  ounce (a teaspoonful), produces a pleasant, cool sensation in salivation, or as a gargle. After holding it for a moment in the mouth, it should be rejected, and an equal amount of the fresh solution may be swallowed. Carbolic acid (10 drops) added makes it more effective in ulceration of the mucous coverings. It seems to act on the nerves locally, the same as chloroform by inhalation does on the body.

In toothache: Chloral, camphor, glycerin, carbolic acid, equal quantities, applied on a small piece of cotton after cleaning the cavity, will relieve the pain. (Cover with more cotton to fill the cavity.) I keep the mixture, ready made, under the name of "Toothache drops," in my medicine case. If the patient has lost sleep I give a full dose of chloral by the mouth.

For ulcerated sore-throat, or ulceration from any cause, such as scalds: Chloral, 10 to 15 drops (grains); water, 1 to 2 ounces, as to age; sugar, to make it palatable to children, a teaspoonful, repeated at short intervals until sleep is induced, then on waking to keep them fully under its influence. My first experience was on my only daughter, four years old. The case was so severe I feared I would lose her, and to get rest for her, gave as above, after having tried everything else I knew of. The almost immediate relief of all the bad symptoms led me to think the medicine acted *otherwise than merely as a rest-producer*. Since then, for ten years I have used it with the utmost satisfaction to myself and patients.

Earache: Camphor, 10 grains; chloral, 10 grains; carbolic acid, 10 grains; castor oil,  $\frac{1}{2}$  ounce. Drop into the ear warm. Fill the ear full, apply a piece of cotton wet in warm water to fill the external ear, then a cloth wrung out in hot water as warm as can be borne. I have seen some almost crazy children go to sleep in two or three minutes, and awake free of their troubles.

As an aid to chloroform in surgery or obstetrics, 10 to 15 grains, given 20 minutes before

administration of the anæsthetic, seems to intensify the effect, and less than one half of it is needed to produce the desired effect. In my obstetric practice for the last fifteen years I have used it, and observed but one case where any unpleasant effects were induced. This was in a woman with her tenth child. I gave the chloral to relax the system, 10 grains; in half an hour 5 grains more; in half an hour the chloroform. It affected her almost immediately, and the child advanced and came away in good style, but the woman seemed to be dead drunk and incapable of moving herself. She slept soundly for several hours and awoke all right. She was conscious and would answer questions, but could not use herself. This was the first time she had taken either of the drugs, and she may have been susceptible—easily affected. Chloral, given before the anæsthetic, seems to tide them over the excited stage of anæsthesia. The first few whiffs of the anæsthetic produce quiet without any excitement, I have used it in a few surgical cases with the same effect. In children a full dose of chloral, and when sleep comes on they are anæsthetized in that state, and the force, often necessary otherwise, is avoided.

In coryza, where the Schneiderian membrane is very irritable, chloral, 10 grains (or drops); castor oil,  $\frac{1}{2}$  ounce, used with a soft mop, applied over the surface, after being dried, acts to check the excretion of mucus, and lulls the irritation and head-pains.

The supposed influence of the drug on the heart has been urged by my friends against its use. I have not seen any unpleasant effects. In any case where there is a chance of any cardiac trouble, it is an easy matter to fortify the heart with a 1-50 grain of nitroglycerin. In one delicate woman I did this as a precaution, but even in her case I believe it was not necessary. This summarizes my experience with chloral, and when I tell you I use from five to six pounds a year, you may know that it has a very considerable scope. I never prescribe it in any quantities, so as to create a "habit." In fact, I do not know of a single case of the kind.—*College and Clinical Record*.

#### SOME RECENT VIEWS ON APPENDICITIS.\*

By J. WILLIAM WHITE, M.D.,

Professor of Clinical Surgery, University of Pennsylvania.

1. The explanation of the great frequency of inflammation of the appendix is to be found in the following facts:—

(a) It is a functionless structure of low vitality, removed from the direct fæcal current; it

\*Conclusions of an address delivered before the Surgical Section of the College of Physicians of Philadelphia.

has a scanty mesentery so attached to both cæcum and ileum that it is easily stretched or twisted when they become distended; it derives its blood-supply through a single vessel, the calibre of which is seriously interfered with or altogether occluded by anything which produces dragging upon the mesentery.

(b) In addition, there is almost always present a micro-organism—the *bacterium coli commune*—capable of great virulence when there is constriction of the appendix or lesions of its mucous coat or of its parietes.

2. The symptoms in a case of mild catarrhal appendicitis—general abdominal pain, umbilical pain, localized pain and tenderness on pressure in the right iliac fossa, vomiting, moderate fever, and slightly-increased pulse-rate—cannot at present with any certainty be distinguished from the symptoms, apparently precisely identical, which mark the onset of a case destined to be of the very gravest type.

3. It must be determined by future experience whether or not operation in every case of appendicitis, as soon as the diagnosis is made, would be attended by a lower mortality than would waiting for more definite symptoms indicating unmistakably the need of operative interference. At present such indication exists in every case if the onset is sudden and the symptoms markedly severe, and whenever in a mild case the symptoms are unrelieved at the end of forty-eight hours, or, *a fortiori*, if at that time they are growing worse.

4. It must be determined by future experience whether cases seen from the third to the sixth day, which present indications of the beginning circumscription of the disease by adhesions, and which tend to the formation of localized abscesses, will do better with immediate operation with the risk of infecting the general peritoneal cavity, or with later operation when the circumscribing wall is stronger and less likely to be broken through. At present, operation is certainly indicated whenever a firm, slowly-forming, well-defined mass in the right iliac fossa is to be felt; or, on the other hand, when a sudden increase in the sharpness and the diffusion of the pain and tenderness points to perforation of the appendix or breaking down of the limiting adhesions.

5. In the beginning of general suppurative peritonitis, operation offers some hope of success. In the presence of general peritonitis with septic pæresis of the intestines, operation has thus far been useless.

6. Recurrent appendicitis of mild type, like acute appendicitis, frequently results from digestive derangements. Several attacks may occur followed by entire and permanent recovery, but it is as yet impossible to differentiate these cases accurately from those which do not tend to spontaneous cure. Operation is certainly indicated whenever the attacks are very frequent.

7. Chronic relapsing appendicitis is characterized by the persistence of local symptoms during the intervals and by more or less failure of the general health. It usually indicates operation.

8. In either the recurrent or the chronic relapsing variety, operation should be advised according to the following indications formulated by Treves: whenever (1) the attacks have been very numerous. (2) The attacks are increasing in frequency and severity. (3) The last attack has been so severe as to place the patient's life in considerable danger. (4) The constant relapses have reduced the patient to the condition of a chronic invalid, and have rendered him unfit to follow any occupation. (5) Owing to the persistence of certain local symptoms during the quiescent period, there is a probability that a collection of pus exists in or about the appendix.—*College and Clinical Record*.

#### TREATMENT OF POTT'S DISEASE.

An interesting and valuable paper on the above subject by Phelps appears in the *Journal of the American Medical Association* for October 27, 1894, in which the following treatment is advised:

In lateral curvature of the spine, effort should be made to develop the muscles of the back by massage and proper gymnastic exercises. The general condition is improved by appropriate food and exercise; and in cases where deviation of the spine amounts to more than half the diameter of the vertebra, a support to prevent absorption of the vertebra at point of curvature is imperatively demanded. In Pott's disease of the spine, however, the principle of treatment is the reverse; it consists in absolute immobilization and extension to the point of comfort to relieve the pressure between the diseased vertebræ.

The plaster-of-Paris corset, or the wood corset with lacings, so that it can be removed at night, are the best forms of brace devised. Aluminum corsets are excellent but expensive. In muscular forms of curvature, corsets with steel stiffening, particularly for young girls, are very satisfactory. These appliances are made while the patient is suspended to the greatest amount possible. This relieves pressure upon the bodies of the vertebræ, and stops absorption. The corsets are removed at night, extension being obtained in the recumbent posture. When the patient is in an upright position, with the corset adjusted, pressure is relieved and absorption must necessarily stop.

In Pott's disease of the spine, the patient is fixed in an apparatus while in the position of suspension, to the point of comfort. The corset which is adjusted is not allowed to be removed; it is put on and permanently worn. The nurse or mother can remove it, which cannot be done with the steel brace. It is worn with comfort, and holding the spine, as

it does, in an extended position, and fixing it better than it can be fixed in any other way, ankylosis will take place.

No brace or corset of any description that will support the spine can be applied effectively to a child under three years of age, owing to the narrow hips. For that reason the writer has devised a plaster-of-Paris portable bed, in which the child is placed; this permits of removal into the open air. Bonet's wire cuirass is a most efficient apparatus, but is more expensive than the plaster-of-Paris portable bed, and no better. If the disease is located above the third dorsal vertebra, no corset or brace without the aid of the jury-mast can be adjusted so as to be a support, owing to the fact that the weight of the head and shoulders operate upon the point of disease or curve. In these cases the jury-mast should always be so adjusted as to transmit the weight of the head through the corset to the hips.

To make proper corsets from plaster-of-Paris, suitable material must be used. H. B. Clafin & Co. make for the author a special crinoline, known as No. 100 hospital crinoline; it has the proper amount of sizing and material and a total absence of indigo. The plaster of Paris is furnished by the White Dental Manufacturing Company, put up in fifty-pound tin packages, fresh from the oven. This cloth and plaster of Paris, when properly united, make a perfect plaster bandage. The crinoline should be torn in strips six inches wide and six yards long; the cloth is drawn over a pile of plaster of Paris on a table, and all rubbed off excepting enough to simply fill the mesh of the cloth; the bandage is loosely rolled, that it may take water quickly. A tight fitting shirt is now adjusted to the patient. The patient with lateral curvature suspends himself to the greatest possible extent. In Pott's disease the arm-pieces are used and the patient suspended to the point of comfort. The dinner-pad is placed under the shirt; three or four bandages placed in water; one of these is wound snugly around the body just above the crest of the ileum, making two or three turns; then the hips are enveloped down to the great trochanter, using one or two bandages at this point. We should begin at the bottom of the corset each time, and roll on the bandages up to the armpits, rubbing each layer until there is no longer air in the meshes of the cloth. Six bandages will do for a child under seven years; from eight to twelve for adults. When the plaster is setting, we should stand behind the patient and gently press the corset in over the crest of the ileum and firmly against the ribs. After the corset has firmly set, the dinner-pad is removed and the corset sprung antero-posteriorly, to throw it off the antero-posterior spinous process, to prevent excoriations. The corset is cut off at the bottom and top, being

left on permanently in case of Pott's disease. In lateral curvature the corset is cut off, the edges trimmed with lacing, and an elastic durable spinal brace results.

If the patient desires a wood corset, fill the plaster-of-Paris corset with plaster, which makes a cast of the body, upon which the wood corset is made.

The corset in Pott's disease should be worn from six months to a year without removal; in lateral curvature it should be removed each night. Proper exercise, forcible redressment, gymnastics, and so on should be used.

The plaster-of-Paris corset is sent to the foundry in case an aluminum corset is desired, the anvil is made, and upon this the aluminum is worked; this is the most beautiful corset made.—*Therapeutic Gazette*.

### THE ANTITOXIN TREATMENT OF DIPHTHERIA.

The topic which just now is absorbing the attention of the profession and the laity almost to the exclusion of all else medical is diphtheria and its treatment by means of Behring's antitoxin. No society meets that the theme is not brought up for discussion, while the writers, the talkers, and the hospital attendants are daily producing an amount of matter so great that the medical press groans to get quit of it, but without avail.

Already the literature of the subject is heavy and voluminous, and he who attempts to read it finds it crude, chaotic, and confusing.

Much winnowing, sifting, and condensing will have to be done before the conscientious doctor who wants the truth, and desires to apply it in practice, can settle the question as to whether he shall inject or not inject, putting his patient to the extra expense of forty or fifty dollars for drugs in each case, or saving him from what is a manifest extortion on the part of the producers of the new remedy.

What is the duty of the general practitioner at this writing can scarcely be set down. If he fail to apply the remedy and the patient should die, he will be severely criticized. If he employ it, and the patient die, he will be accused of having experimented upon the victim with a fruitless and expensive fad. If, however, the patient should recover under the new remedy, it may still be said that many patients have gotten well, and probably this one would have done so without the antitoxin, and that still the doctor is experimenting with expensive and fruitless fads.

Just what the doctor's duty in the case is cannot be stated till time shall give us a great number of reports, and some gifted compiler shall deduce from the vast accumulation of literature upon the topic a volume of statistics reducing the question to a mathematical certainty. Till then we think the practitioner would do well to lay the question of the new



treatment fairly before each patient or his friends, and to advise its use in all cases where in the financial condition of the family will allow of it.

Statistics to date, so far as they are attainable, pronounce the treatment effective in the saving of life; but the usual liberal discount must be made in drawing conclusions from the reports of enthusiastic experimenters with new remedies.—*American Practitioner and News*.

#### PERNICIOUS ANÆMIA AT THE AGE OF TWENTY-ONE.

Pernicious anæmia is not often met with during the first twenty five years of life, and a case observed by Dr. W. R. Gowers, of London, is therefore worthy of mention. The patient, a young man aged 21 years, seen February 19, presented the appearance of extreme chlorosis, the skin having the characteristic tint, the gums and conjunctivæ being very pale. He was feeble and readily rendered short of breath. The condition had come on gradually during the previous six months; before which time the patient had seemed in good health, though he had been delicate as a young child. The percentage of hæmoglobin was but a little over 30, and of red corpuscles only 25 per cent. Examination of the eyes showed numerous flamed-shaped hæmorrhages in each retina, and one or two, of more irregular shape, near the disc. Hæmorrhages had occurred a month previously. In spite of careful treatment the patient steadily failed. There was some elevation of temperature for a few days, and pyrexia returned on March 19th, when a large hæmorrhage occurred in the right eye. Vomiting set in, and the patient died on March 21st.

Such a case, says Dr. Gowers, lends itself to the current tendency to associate all sorts of diseases with specific organisms; but another hypothesis deserves consideration, viz., the failure of tissues soon after they complete their development, not unknown in other structures,—an inherent defect of vital endurance on the part of the blood-making tissues.—*British Medical Journal*, May 12, 1894.

#### MENINGITIS OF OBSCURE CAUSATION.

Dr. F. Carr Bottomley, of St. George's Hospital, London, in a study of this subject, arrives at the following conclusions: 1. It is difficult to say whether certain cases of meningitis have been due to tubercle or not. Meningitis may probably be tuberculous without any tubercles being visible in the meninges,—at any rate, to the naked eye. Bacteriology helps us to decide whether this has been the cause. 2. It is also difficult to decide whether certain cases are due to ear disease; the presence of signs of old or recent otitis media does not

necessarily show that the meningitis was secondary to this; bacteriology probably helps us to decide the question only in the case of old ear disease. 3. Some cases of meningitis following broncho-pneumonia and empyema are probably of a septic nature. 4. There is no evidence of Bright's disease being a cause of meningitis. 5. Idiopathic cases are characterized by the following points: (a) Both brain and spinal cord are frequently attacked, and spinal symptoms are common; these symptoms are rare in other varieties of meningitis which attack both brain and cord, if we consider retraction of the head to be not necessarily a spinal symptom. In some cases spinal appear before cerebral symptoms. (b) The duration of illness varies from one to four weeks, the variation depending mainly on the stage of the disease at which the cerebral membranes become affected. (c) Recoveries are fairly frequent. (d) The best treatment seems to consist in the administration of mercury and iodides. (e) The affection of the cerebral membranes may be either at the vertex or the base, or both. (f) The cases occur perhaps most frequently in the cooler part of the year. 6. There is some evidence for considering these cases to be associated with epidemic meningitis, and for considering that the cause of both may be the *diplococcus pneumoniae*.—*Practitioner*, June, 1894.

#### A CASE OF TÆNIA NANA IN A CHILD.

Dr. Rasch, of Bangkok, had under his care a girl of 7 years, in whom disturbances of digestion, combined with an insomnia which could not be accounted for, led him to suspect the possibility of helminthiasis. Examination showed the presence of oxyuris and the eggs of tænia. Male fern was administered, and a large quantity of white filaments, fifty or eighty in number and one or two centimetres in length, were passed, which proved to be the tænia nana. The child has never been out of Siam.

Tænia nana is rare in the human subject, but three or four cases having so far been reported by Billarx, of Cairo; Blanchard, of Belgrade; and Grassi, of Sicily.—*Deutsche medizinische Zeitung*, No. 13, 1894.

#### THE VALUE OF SUGAR AND THE EFFECT OF SMOKING ON MUSCULAR WORK.

As the result of a series of experimental researches in the Physiological Institute, Turin, upon this subject, Vaughan Harley has come to the following conclusions: 1. The periods of digestion as well as the kinds of food taken have a marked influence on voluntary muscular energy. 2. Irrespective of the influence of food, there is a periodical diurnal rise and fall in the power of performing muscular work. 3. More work can be done after

than before mid-day. 4. The minimum amount of muscular power is in the morning about 9 A.M., the maximum about 3 in the afternoon. 5. Regular muscular exercise not only increases the size and power of the muscles, but has the effect of markedly delaying the approach of fatigue. 6. The amount of work performed on a diet of sugar alone is almost equal to that obtained on a full diet, fatigue, however, setting in sooner. 7. In fasting, large quantities of sugar (500 grammes) (16 ounces) can increase the power of doing muscular work during 30 voluntary contractions from 26 to 33 per cent., while the total gain in a day's work may be 61 to 76 per cent., the time before fatigue sets in being also lengthened. 8. The effect of sugar is so great that, when added to a small meal, it can increase the muscular power during 30 contractions from 9 to 12 per cent., while the total increase in work may be from 6 to 39 per cent., the approach of fatigue being at the same time retarded. 9. When added to a large mixed meal, sugar can increase the muscular power of 30 contractions 2 to 7 per cent., the increase in total work being 8 to 16 per cent., and a marked increase in the resistance to fatigue is shown. 10. Two hundred and fifty grammes (8 ounces) of sugar taken in addition to a full diet increase the day's work; the work accomplished during 30 voluntary muscular contractions shows a gain of from 6 to 28 per cent., the total day's work giving an increase of power 9 to 36 per cent., and the time before fatigue sets in being lengthened. 11. Moderate smoking, although it may have a slight influence in diminishing the power of doing voluntary muscular work, neither stops the morning rise nor, when done early in the evening, hinders the evening fall. 12. Sugar taken early in the evening is capable of obliterating the diurnal fall in muscular power that occurs at this time, and increases the resistance to fatigue.—*Journal of Physiology*, vol. xvi, Nos. 1 and 2, 1894.

### SCORBUTUS IN INFANTS.

Dr Wm. P. Northrup advances the following conclusions, based on an exhaustive study of the subject; 1. Scurvy may appear at any period of infancy or early childhood, but is most common between the ninth and fourteenth months. 2. The lesions are hæmorrhagic in character, due probably to diapedesis. The most characteristic are subperitoneal hæmorrhages. Hæmorrhages into the muscular tissues, the skin, and mucous membrane are more or less constant. 3. It occurs in every grade of the social scale, but is more frequent among the rich than the poor. The neglected child who eats everything at table may become rachitic or marasmic, but he obtains enough fresh food to protect him from scurvy. It very rarely occurs in asylums and hospitals, because, in recent years feeding in

such institutions has been more rational than in many private families. 4. Lack of fresh food is the most important cause. The use of the proprietary foods and condensed milk produces more scurvy than all other causes combined. Even fresh milk in small proportions is not sufficient to insure protection. 5. Anæmia and malnutrition are almost invariably present; a peculiar sallow complexion is common. 6. Scurvy is frequently superadded to rachitis, but in a considerable number of cases no evidences of rachitis are present. So-called acute rickets is in most cases, probably in all rickets, complicated by scurvy. 7. Pain is a constant symptom; it develops early and is usually intense. 8. A varying degree of immobility of the extremities is common, and is frequently so marked as to simulate paralysis. This pseudo-paralysis disappears with the subsidence of the scorbutic symptoms. 9. Subcutaneous hæmorrhages, as well as hæmorrhages from the cavities of the body, are very common, but are not necessary to a diagnosis of scurvy. 10. The condition of the gums is characteristic. They are purplish, soft, spongy, and bleeding, and frequently show decided ulcerations. When the teeth have not been erupted, changes in the gums are usually slight or entirely absent. 11. Painful swelling of the lower extremities is the most constant symptom; the upper extremities are rarely involved. The thigh is affected more frequently than any other region. 12. Children suffering from scurvy commonly present the following symptoms: anæmia, intense pain on motion, spongy and bleeding gums; swelling of the lower extremities, usually at the thigh. There may also be purpura or ecchymoses, discharge of blood from the various cavities of the body, and pseudo-paralysis. 13. Scurvy, when untreated, is a very fatal disease; when recognized and properly treated, a rapid and complete cure is usually effected. The result of anti-scorbutic treatment is, in fact, one of the most certain means of diagnosis. 14. Scurvy may be mistaken for rheumatism, stomatitis, rickets, sarcoma, osteitis, and infantile paralysis. 15. Scurvy is a dietetic disease, and must be cured by dietetic treatment. Fresh milk, beef-juice, and orange-juice are the most effective remedies.—*New York Medical Journal*, May 26, 1894.

### SUBCUTANEOUS INJECTION OF ARTIFICIAL SERUM IN SERIOUS HEMORRHAGE.

Lemoine reports the case of a young woman, who lost a large amount of blood during pregnancy, cured by the injection of artificial serum.

The liquid employed has the following composition:

Sodium phosphate,  
Sodium chloridæ, of each, ʒii;  
Water, Oii.

He injected 1½ pints of this fluid into the buttocks of the patient, and three hours afterwards the symptoms, as well as the fluid, had totally disappeared.—*Revue Médico-Chirurgicale des Maladies des Femmes*, August 25, 1894.

### CLASS-ROOM NOTES.

—*Digitalis*, Prof. Hare says, is a powerful stimulant to the heart, and not a sedative.

—*Colchicine*, Prof. Hare says, does not disorder the stomach as easily as colchicum.

—*Appendicitis*, Prof. Keen says, occurs about three times as often in the male sex as in the female.

—Prof. Hare says the *Oil of Copaiba* is not as therapeutically active as the balsam of copaiba.

—Prof. Keen says *Gall-stones* that escape from the gall-bladder will often be the cause of obstruction at the ileo-cæcal valve.

—Prof. Hare is of the opinion that some cases of *Pneumonia* can be aborted if they are seen early enough.

—Prof. Montgomery says *Lacerated Perineums* sewed up during the period of lactation often do not heal well.

—*Chloral*, according to Prof. Hare, is the best and purest hypnotic, but it will not relieve pain.

—*Fungous Growths* at the stump of the umbilical cord, Prof. Parvin says, can generally be gotten rid of by dusting with burnt alum.

—Large doses of atropine, Prof. Hare says, should not be administered to *Nursing Mothers*, since it is largely eliminated in their milk.

—Prof. Parvin believes that an excessive and overworked condition of the kidneys is the cause of *Albuminuria* in the pregnant woman.

—*Convulsions* at the outset of pneumonia, Prof. Wilson says, are of very common occurrence in children, taking place in almost one-half of all the cases.

—According to Prof. Parvin, if, after eighteen hours from time of delivery, the mother does not voluntarily empty the bladder, she should be catheterized.

—Prof. Montgomery says the dressings in a case of *Abdominal Section* should not be removed for ten days after the operation, unless complications set in.

—Prof. Parvin does not think that hamamelis is a safe remedy to administer to a woman in the treatment of *Hemorrhoids*, if she be in a pregnant condition.

—In a *Depressed Fracture of the Skull*, Prof. Keen says, even if no nervous symptoms manifest themselves, the skull should be trephined and the depressed part elevated.

—If the temperature in *Diphtheria* remains high for days at a time, Prof. Wilson says it is due generally to some pulmonary or other complication and not to the diphtheria itself.

—One of the most prominent symptoms of *Fracture of the Clavicle*, Prof. Brinton says, is that the patient is unable to place the hand of the injured side on the shoulder of the sound side.

—Prof. Wilson says the chill which, as a rule, is present at the outset of an attack of *Pneumonia* often does not manifest itself in children, but is supplanted by nervous symptoms.

—Prof. Brinton does not favor, in cases of *Fracture of the Humerus*, the splinting of the upper arm only, and leaving the forearm without any splint or support other than a sling.

—For *Enlarged Thyroid Glands*, Prof. Parvin recommends the local application of an ointment consisting of from twenty to thirty grains of the biniodide of mercury to half an ounce of simple ointment.

—Prof. Brinton says, in examining the *Scapula* for possible fracture, the arm should be carried behind and upward on the back, which will cause the scapula to extend prominently.

—Prof. Wilson says a peculiarity of *Rheumatic Fever*, which in obscure cases becomes an important diagnostic point, is the occurrence of irregular sweats, which bear no relation whatsoever to the fall of the temperature.

—Prof. Hare says there is no drug which has as good an influence on true *Gout* as colchicum. The best preparation to use in these cases, he thinks, is the wine of the root of colchicum, in the dose of from five to twenty drops.

—When *Diphtheritic Exudations* are laryngeal or sublaryngeal, Prof. Wilson says steam inhalations, consisting of one part alcohol and five parts of water, will be found not only to give much relief, but to be also very beneficial.

—In any case of *Injury to the Head*, in which a patient vomits blood, Prof. Keen says a fracture of the base of the skull will be found in nine out of every ten cases. The vomited blood will be blood that has trickled from the fracture and has been swallowed by the patient.

—Prof. Parvin says that one of the differential diagnostic signs between *Hydræmia* and *Albuminuria* in the pregnant woman is that the œdema of the lower limbs in hydræmia disappears when the patient is at rest, while if it be due to an albuminuria, it does not disappear.

—Prof. Wilson says in a case of *Croupous Pneumonia*, when the disease extends itself from one lobe of the lung to another, or when it travels from one lung to the other, we do not have a chill such as manifests itself at the outset of the disease.

—In cases of *Injury to the Head*, Prof. Keen says if at the edges of the wound a ring is formed by the effusion which is hard and well marked, it will no doubt be found to be a contused wound; while if the margins of the wound are found to be soft and not well marked, the chances are that a depressed fracture has taken place.

—Prof. Parvin says if *Excessive Uterine Contractions* occur, and on account of the unyielding condition of any portion of the birth canal, a tear is likely to take place from rapidity of the labor, free inhalations of chloroform must be given in order to moderate the uterine forces.

—Often in the new-born, Prof. Parvin says, within a week, both in the male and in the female child, a *Secretion of Milk* occurs; this is best gotten rid of by bathing the breast in hot water and then applying a warm mixture of three parts of sweet oil and one part of camphor.

—Prof. Hare does not think that chloroform is a very good remedy in cases of *Puerperal Eclampsia*, on account of the danger of post-partum hemorrhage due to the relaxation of the muscles of the uterus. There is also the danger from its use of cardiac failure brought on by a sudden exertion due to the convulsive movements of eclampsia.

—In *Pneumonia*, when the disease attacks the lower lobes of the lungs, Prof. Wilson says the pain is more severe than if another part of the lung is attacked.

—Prof. Hare says cases of *Tonsillitis*, especially if associated with rheumatism, will very often be relieved by guaiac, when all other drugs seem to yield no effect.

—Prof. Parvin says that it has been noted that *Eclampsia* manifests itself with special virulence at times in a certain territory, and at special times more than at others.

—In the intermitting form of *Malarial Fever* the paroxysms of fever last from three to four hours, while in the remittent form they last from fifteen to eighteen hours, according to Prof. Wilson.

—Any case of *Epilepsy* developing suddenly in a patient who is passed thirty-five years of age, and who gives no history of injury, Prof. Hare says is almost invariably caused by syphilis.

—The most efficient remedy that can be employed in cases of *Cystitis* in the female, according to Prof. Parvin, is the washing out of the bladder with a weak solution of creolin.

#### THERAPEUTIC BRIEFS.

—Iodine has been found to be one of the most effective agents for destroying the parasite upon which RINGWORM depends. (*Modern*

*Medicine*.) An excellent method of applying it is the following: Thoroughly cleanse the scalp with soap and water. Dry perfectly, then apply a solution of one part of pure iodine in thirty parts of flexible collodion. Renew the application each day for four days. At the end of fifteen days, remove the collodion, wash the scalp first with soap and water, then, after thoroughly removing the soap, wash with a hot solution of bichloride of mercury, 1-2500. After allowing the bichloride solution to remain in contact with the scalp for half an hour, wash with pure water, dry, and apply vaseline or zinc ointment. If necessary, repeat the application.

—For relief of PRURITUS, the following application suggested by Bronson has been found useful:—

℞. Acid. carbolic.,  
Liquor. potassæ,                   āā f3j  
Olei lini,                               f3j  
Olei bergamot,                       gtt. ij. M

SIG.—Shake well and apply locally.

—ICHTHYOL is proving itself to be one of the most valuable drugs in the materia medica. (*Modern Medicine*.) An ointment consisting of twenty-five per cent. of ichthyol and seventy-five per cent. of lanolin is the very best remedy for erysipelas. Ichthyol is also useful in rheumatism, in the form of an ointment consisting of equal parts of lanolin and ichthyol.

—The following is an excellent ANTISEPTIC SNUFF-POWDER (Dr. L. A. Dessar, *International Journal of Surgery*):—

℞. Menthol,                           10.0  
Tannic acid,                         2.0  
Boric acid,                           30.0  
Bismuth subnitrate,               20.0  
Starch,                               50.0  
Cocaine,                              50.0  
Aristol,                               āā 0.5

SIG.—Make a fine powder.

—FOR CHILBLAINS (*Amer. Med. Surg. Bulletin*) Dr. James R. Wood employs the following:—

℞. Zinci oxidi,                         3j  
Camphoræ pulv.,  
Myrrhæ pulv.,  
Opil pulv.,                           āā gr. xxx  
Adipis,                                 5j. M

—FOR PAINFUL DEFECATION, attending inflammatory pelvic conditions, Dr. Murray (*Norsk Magazin for Lægevid*) recommends the following:

℞. Bismuth subnitrate,           gr. ijss  
Mercurial ointment,               gr. iss  
Extract of belladonna,           gr. ivv  
Cacao butter, q.s., for  
  one suppository.

SIG.—Two suppositories a day. The bismuth is added to prevent irritation of the mucous membrane of the rectum.

# THE CANADA MEDICAL RECORD

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MONTREAL, APRIL, 1895.

## CANADA MEDICAL ASSOCIATION.

From recent letters received from one of the local officials of the next meeting of the Canada Medical Association at Kingston at the end of August, as well as from the venerable and esteemed President, Dr. William Bayard, of St. John, we have every reason to believe that the Kingston meeting of our national Association will be one of the most successful yet on record. The time chosen for the meeting is a most convenient one, and every physician in Canada should feel it his duty, as well as a pleasure, to be present. Of course it entails financial sacrifice at the moment, but the expense should be looked upon as a good investment, which will bring in a large dividend, in the shape of increased health and strength; mentally and physically, for the following winter's work.

The physicians of the Province of Quebec, especially, who have no provincial society of their own, should all the more feel bound in honor to attend the national society at Kingston, during the latter part of August.

If each one would hand in a brief report of a case occurring in his practice, the success and interest of the meeting will be doubly assured. It is a mistake which many general practitioners make, in thinking that the Association only wishes to hear profound and learned disquisitions on rare or unknown diseases. What seems to please these meetings most are papers full of rich experience, or simply and briefly record-

ing a case, with its treatment and results. Most of those who attend these meetings are general practitioners, and what interests the general practitioner generally interests the whole meeting.

## THE INTERNATIONAL LANGUAGE OF THE FUTURE.

We regret to see by an editorial of one of our big New York contemporaries, that the editor speaks quite seriously of the advantages of Greek as the universal language of the future. While admitting that modern Greek is a very beautiful, soft and flexible language, yet the mere fact that it is one of the least spoken languages of the world, that is to say, spoken by the fewest number of the people in the world, renders it unsuitable for a universal language. We have always maintained that, as the English language is already spoken by the vast majority of the inhabitants of the earth, it would entail the expenditure of the smallest amount of energy if those who do not speak it should make a point of becoming familiar with the English language. The present method of having a great number of different languages to express their views in consumes an enormous amount of energy among those who are writers of medical literature.

## THE OUTLOOK FOR MEDICAL STUDENTS.

From recent statistics it appears that the supply of medical students for the United States is, at the very lowest, three times as great as it is in Great Britain or France. It is no wonder that medical men complain of hard times when competition must necessarily be so keen. We presume that a rather large percentage of American medical students fall by the wayside, or, if they graduate, fail to pursue their profession. It is at best hard to understand how 800 new members every year can earn a living. It is, in fact, becoming constantly harder for a young medical man to get a foothold. He must either begin practice in a country village, or, if he is desirous of practising in the city, he must have private means to enable him to keep up a good appearance for three or four years, without his having been able to earn a cent.

## THE DUTY OF NAVAL SURGEONS.

Quite a little tempest in a teapot has been raised in naval and military circles in the United States over the charges brought against a naval surgeon, that while on board his ship in the West Indies, he declined to take charge of a sick man on a Nova Scotia ship, the captain of which had signalled to the man-of-war to send its surgeon on board.

It is evident that if the man-of-war had not been there at the time, no one would have thought of having it sent there for the purpose of attending this sailor on the merchant ship; so that if the naval surgeon declined to take his case in hand, the sailor was no worse off than he was before having met the American man-of-war.

The naval surgeon, in defending himself, said that he was employed by the government to attend to the health of those on board, and he was in no way responsible for the health of the inhabitants of another ship. The idea of bringing a charge against him for not leaving his own patients and taking the care of a patient about whom he knew nothing, and that while in the employ of the United States Navy, seems extremely absurd.

## THE NEW YORK ACADEMY OF MEDICINE.

We are pleased to see by the treasurer's report for last year, that this institution is in a prosperous condition, having assets of nearly half a million dollars. The number of resident fellows is 774; the bureau for nurses has been self-sustaining, and added something to the treasury. 350 nurses have been registered and 180 calls for nurses have been responded to.

We hope that the time is not far distant when Montréal will also have its Academy of Medicine. The Medico-Chirurgical Society alone has a membership of 125, or about one-sixth of the number of members of the New York Society. If Montréal had even one-sixth of that which represents the assets of the New York Society, it would have some \$86,000.00. Could not this amount be raised among the wealthy merchant princes of the city? There seems to be no difficulty in raising \$100,000.00 every now and then for various educational institutions. Does any institution do more to educate the medical pro-

fession than the Medico-Chirurgical Society of Montreal, or is any institution more deserving of support?

We think the time has come now when the members should begin to collect a fund for the purpose of obtaining a permanent home for the Medico-Chirurgical Society, worthy of its high-class personnel, and worthy of the excellent work which it performs.

The bureau for nurses is still more urgently needed in Montreal than the home for the Society. For at present, medical practitioners have the greatest difficulty in hunting around for a nurse, when needing one in any emergency; while, if a bureau for nurses in connection with the Medical Society were established, a superintendent, who might be one of the nurses themselves, in turn and without salary, might always be on hand, night and day, and knowing from day to day exactly which nurses were disengaged, she could at once send them a message where to go, by means of a telephone messenger. We hope that our influential contemporary, the *Montreal Medical Journal*, will take this matter up.

## PATENT MEDICINES.

During the last year or two, many a hard-working, struggling practitioner must have felt keenly the rivalry or the competition of the wealthy patent medicine manufacturer. While the physician cannot say one word in his own defence, the patent medicine man fills the daily papers with column after column of certificates, real or fictitious, of cures which his medicine has worked, and even in many cases the physician is publicly held up to contempt. Many of the statements in these advertisements are utterly false, as indeed are most of the testimonials. The public in general take everything they see in the papers for gospel truth, not knowing that the man who contracts for so much space, at an enormous cost, is at liberty to insert anything he pleases in those columns, without any regard whatever for the truth. So that we see thousands of people resorting to the drug store to purchase these patent medicines, the value of which has been vouched for by certificates from clergymen, acting in good faith, but unable to judge of the truth of their statements; from lawyers and

literary men, the latter of whom, of course, are well paid for their contributions.

The family doctor feels still more aggrieved when the patient whom he sends to the drug store to have a prescription filled comes back sometimes without the prescription, but with a bottle of patent medicine which the storekeeper has told him was much better for his case.

We have often thought that something should be done by the profession to protect itself from the insults heaped upon it in the text of these advertisements, but, according to the *New York Medical Record*, the sale of patent medicines has reached its highest point, and will gradually fall little by little as commercial prosperity returns. He has it on the authority of the editor of a large daily paper that the sale of patent medicines always increases during hard times, for the simple reason that people cannot afford to employ a doctor, or think that it is more economical to prescribe for themselves, and thereby save a doctor's fee. He believes that the great sale of patent medicines is only one indication of the hard times, and as soon as general business revives, the people will again indulge in the luxury of medical advice for minor ailments.

We have on more than one occasion ventured to suggest to our readers that they should accommodate their fees to the requirements of the times, and that when every one is more or less out of employment, or has his wages cut down, it will pay the doctor to reduce his fee in proportion, and to obtain the medicine for his patients at the lowest possible price consistent with quality.

Another thing which might be done to diminish the injury done to the profession by patent medicines would be for the physicians of a city to unite in patronizing a druggist who would undertake not to keep any patent medicines or proprietary articles, or, in other words, not to dispense on his own account, but to limit his business to the filling of physicians' prescriptions only.

#### MEDICAL ITEMS.

##### *Post Graduate Course in Gynecology.*

At the request of a number of practitioners, both in Montreal and in neighboring towns, Dr. Laphorn Smith will, on the 1st of June, begin a post graduate course on the diagnosis and

treatment of gynecological diseases. Only a very limited number will be taken, so that each one may become thoroughly familiar with this department of medicine. Those desiring to join the class should apply early.

We were sorry to learn that Dr. Lockhart was in poor health and had been obliged to relinquish practice for a time in order to take a rest and to recuperate abroad. Accompanied by his wife and her sister, he left a month ago for a trip to the Mediterranean, from which we are glad to learn he is soon about to return much restored in health.

A very successful entertainment was given this month at the Queen's Theatre, in aid of the Samaritan Hospital for Women. Lady Aberdeen came down from Ottawa to attend it, and there were present almost all the leading people of the city, all the boxes as well as every seat in the body of the theatre and the balcony being filled. The result financially was all that could be desired, the receipts amounting to seven hundred and fifty dollars.

Dr. Macphail, who, for some years, has had his office on St. Catherine street, has moved into his fine new residence on Peel street. The Doctor is a general favorite with the profession, and we wish him many years of health and prosperity in his new home.

## BOOK NOTICES.

CLINICAL GYNÆCOLOGY, MEDICAL AND SURGICAL. For Students and Practitioners. By Eminent American Teachers. Edited by John M. Keating, M.D., LL.D., and by Henry C. Coe, M.D., M.R.C.S., Professor of Gynæcology, New York Polyclinic. Illustrated. Philadelphia: J. B. Lippincott Company.

This, the latest work on gynæcology, was begun under the joint editorship of two of our most brilliant workers; but before it was very far advanced, Dr. Keating died, and the whole of the onerous duties of editing fell upon Dr. Coe. That he has had a remarkable success in accomplishing them is evident from a careful perusal of the book which lies before us. First of all, it is up to date, and those who are keeping abreast of the wonderful advances in gynæcology know what that means; for books that were thoroughly modern three or four years ago are already behind the times now. The next point that impresses us is the ability and high standing of the collaborators. First, there

is the introductory chapter by Dr. Goodell, who has since died—a chapter which should be read and re-read by every practitioner of medicine. His voice is like that of a prophet crying out in the wilderness, warning us of the errors and abuses into which those who practise in this department are too ready to fall. His great motto is: attend to the general health first before attacking the ovaries or womb; and he points out the causes of diseases of women with the wisdom of a master brain and the skill of a master hand. Dr. Goodell is dead and has gone to his rest, but his words in this beautiful introductory chapter will live after him. We were almost going to say that it alone was worth the whole price of the book. He warns us that the Anglo-Saxon stock of Americans is dying out, owing to the avoidance of conception and the production of abortion among the better classes, and he shows how unhealthy and unwholesome is the present education and mode of life of our women. The article by Drs. Baker and Davenport, of Boston, on "Methods of Gynæcological Examination," is one of the best of its kind that we have ever seen, every point being richly illustrated. Dr. Hunter Robb's article on "Gynæcological Technique" is also very good, occupying some eighty pages. Then follows Dr. Bache Emmett's article on "Gynæcological Therapeutics," and Dr. Mann's on "Traumatic Lesions of the Vulva, Vagina and Cervix." Dr. Polk has an elaborate article of one hundred pages on "Inflammation of the Female Genital Organs," and Dr. Whitridge Williams a short, but entirely new, chapter on "Genital Tuberculosis," about which very little has hitherto been known. Then follows a fine article by Boldt on "Neoplasms of the Genital Tract as far as the Uterus," while Dr. Coe himself contributes over a hundred pages on "Neoplasms of the Tubes, Ovaries and Broad Ligaments." Dr. Coe's article is the gem of the whole work, and should be read by every one before attempting pelvic surgery of any kind. The other articles by Lusk, Jewett, Palmer and Montgomery are all good. The writers of these chapters are all teachers, and the result is that all they have to say is of an exceedingly practical nature. In the few instances in which they tread upon each other's ground, it is rather an advantage than otherwise, for it gives one a better idea of how two different men accomplish the same work. Altogether, we have thoroughly enjoyed the reading of this book, so elegantly written and so profusely illustrated with nearly one thousand engravings. In this respect, as well as in the printing, paper and binding, the publishers have treated their authors generously. The book can be obtained through Mr. Renouf, St. Catherine street, Montreal.

SAUNDERS' NEW AID SERIES. Dose-Book and:

Manual of Prescription-Writing, with a list of the official drugs and preparations, and also many of the newer remedies now frequently used with their doses. By E. T. Thornton, M.D., Ph.G.; Demonstrator of Therapeutics, Jefferson Medical College of Philadelphia; Acting Assistant-Surgeon United States Marine Hospital Service. Philadelphia: W. B. Saunders, 925 Walnut street. 1895.

This is a very handy volume, suitable for the doctor's office desk, as it contains in an accessible form an immense amount of information on the dosage of drugs, but gives many valuable suggestions on prescription writing. The price is \$1.25.

A MANUAL OF BANDAGING, Adapted for self-instruction. By C. Henri Leonard, A.M., M.D. Professor of the Medical and Surgical Diseases of Women, and Clinical Gynæcology in the Detroit College of Medicine. Sixth edition, with 139 engravings. Cloth, octavo, 189 pages. Price \$1.50. The Illustrated Medical Journal Co., Publishers, Detroit, Mich.

The main feature for commendation of this book over other similar works is that each illustration shows the direction of the various turns of the bandage with arrow-heads, and each turn is properly numbered; this renders the book a self-instructor to the reader of it, who has but to put the various bandages about the limbs of an office companion a few times, when the "trick" of its application upon a patient has been learned. It takes the place, in this way, of hospital drill. Besides the "Roller Bandages," the various "T's Cravats," "Slings," "Tailed," "Adhesive" and "Plaster" bandages, and "Immovable Dressings" are given. The book is divided into sections treating of "The Bandages of the Head," of "The Body," of "The Upper Extremity," of "The Lower Extremity," "Knots," "Strappings," "Compresses" and "Poultices" with full description of making and applying the same. There is an illustration for nearly every bandage described. It has been recommended as a text-book in various medical colleges and hospitals in this country, and has had two editions sold abroad. A medical student could profitably spend his vacation evenings in mastering the application of bandages by using this book as a guide, and to a practitioner it would not come amiss.

THERAPEUTIC SUGGESTION in Psychopathia Sexualis. (Pathological Manifestations of the Sexual Sense.) With especial references, to Contrary Sexual Instincts. By Dr. A. von Schrenck-Nolzing, Practising Physician in Munich. Authorized Translation from the German. By Charles Gilbert Chaddock, M.D., Professor of Diseases



of the Nervous System, Marion-Sims College of Medicine; Member of the American Medico-Psychological Association, Member of the St. Louis Medical Society, Attending Neurologist to the Rebekah Hospital, Fellow of the Chicago Academy of Medicine, Corresponding Member of the Detroit Academy of Medicine, etc. One volume, royal octavo, 325 pages, extra cloth; \$2.50 nett. Sold only by subscription to the medical profession only. Philadelphia: The F. A. Davis Company, Publishers. London: F. J. Rebman.

### PAMPHLETS RECEIVED.

**RESECTION OF THE KIDNEY.** By M. Stamm, M.D.; Fremont, Ohio, Professor of Operative and Clinical Surgery in the University of Wooster, Cleveland, Ohio. Read before the Detroit Medical and Library Association. Reprint from Columbus Medical Journal, September 18, 1894.

**IMPRESSIONS OF AMERICAN MEDICAL SCHOOLS.** An Address delivered to the Medical Students of Queen's University, by Kenneth N. Fenwick, M.A., M.D., Professor of Gynæcology, Queen's University, Kingston, Ont.

**THE SURGICAL TREATMENT OF INGUINAL HERNIA.** Marcy.

### PUBLISHERS DEPARTMENT.

#### LATE LITERARY NEWS.

#### RUDYARD KIPLING TO RETURN TO INDIA.

Rudyard Kipling will shortly return to India, where he will prepare, for *The Cosmopolitan*, twelve articles to appear in the American and English editions of that magazine. India is one of the most interesting of countries, and Mr. Kipling is able to write of it as no one else. His work will be looked forward to with world-wide expectation.

Perhaps the most beautiful series of pictures ever presented of the Rocky Mountains will be found in a collection of fourteen original paintings, executed by Thomas Moian for the *May Cosmopolitan*. To those who have been in the Rockies, this issue of *The Cosmopolitan* will be a souvenir worthy of preservation. This number contains fifty-two original drawings, by Thomas Moran, Oliver Herford, Dan Beard, H. M. Eaton, F. G. Attwood, F. O. Small, F. Lix, J. H. Dolph, and Rosina Emmett Sherwood, besides six reproductions of famous recent works of art, and forty other interesting illustrations—ninety-eight in all. Though *The Cosmopolitan* sells for but fifteen cents, probably no magazine in the world will present for May so great a number of illustrations specially designed for its pages by famous illustrators. The fiction in this number is by F. Hopkinson Smith, Gustav Kobbé, W. Clark Russell, Edgar W. Nye, and T. C. Crawford.

#### A SPRING-TIME MAGAZINE.

Women's colleges receive Dr. Parkhurst's attention in the *May Ladies' Home Journal*, and the vigor with which he treats the subject is unmistakable. His words open up new phases of college training for women which will unquestionably command not only wide attention but wide discussion. The fact that Florence Nightingale reaches the ripe age of seventy-five this month is made the basis for an interesting sketch of "The Angel of the Crimea," as she is to-day, showing a new portrait of her and a view of her London home. Elizabeth Stuart Phelps is tenderly reminiscent of her father, the late Austin Phelps, in the series of "The Man Who Most Influenced Me." Edward Bok answers, with much force and directness, a page of "Problems of Young Men." There is a strong flavor of interesting biography to this number of the *Journal*—sketches, with portraits, of the home lives and personalities of "The Wives of Three Authors," Mrs. George W. Cable, Mrs. Conan Doyle and Mrs. Thomas Hardy, being given on one page, while Frank S. Guild gives a sketch of the popular artist, A.ice Barber Stephens, and Ethel Mackenzie McKenna writes of Marie Corelli. John Kendrick Bangs is irresistibly funny in his report of the sixth meeting of "The Paradise Club." The full score of the "Concert Mazurka," by the well-known composer, Bruno Oscar Klein, the piano composition which won the second prize in the *Journal's* musical series, is given. Exquisitely illustrated and timely articles are Mrs. Mallon's "Dainty Commencement Gown," and "The Silks of the Summer." Miss Hooper writes of "The Newest Dress Designs," and Mrs. Hamilton Mott contributes a valuable article on "The Art of Travelling Abroad." Women who are ordering their summer stationery will be interested in Mrs. Garret Webster's article on "The New Circle for Stationery." "Ecclesiastical Embroidery," by Harriet Ogden Morrison, is illustrated from original designs. The cover of this *May Journal* is a reproduction of one of Albert Lynch's beautiful girls, set into an artistic frame. This beautiful magazine is sold at ten cents per number and at one dollar per year, by the Curtis Publishing Company, Philadelphia.

The four weekly issues of *Littell's Living Age* for April are as usual overflowing with the best things that current foreign literature affords, and present a wider range of thought and style than is to be obtained in any of the monthlies, as may be seen by the partial table of contents given below:

"Some Recollections of Robert Louis Stephenson," by H. Bellyse Baildon; "The Method of Teaching Languages," by John Stuart Blackie; "John Lyly and his 'Euphuës,'" by H. Lacey; "The Referendum in Switzerland," by Numa Droz; "Lord Randolph Churchill," by Sir Herbert Maxwell; "A Visit to the Buddhist and Taoist Monasteries on the Lo Fau San," by E. A. Irving; "Robert Southey," by George Saintsbury; "The Crisis in Newfoundland," by William Greswell; "Women of the French Revolution, the Great Citoyenne (Madame Roland)," by M. Dale; "The Romance of a Stuart Princess," by Mrs. W. E. H. Lecky; "The Sancho Panza of Madagascar," by Julian Corbett; "Two Modern Poets," by H. D. Trail; "Up the Yangtze," by Lise Boehm, with many other papers of nearly equal value, besides poetry and fiction.

The fiction in these numbers is by Charles Lee, M. R. James, D. Storrar Meldrum and E. Chilton. The authors of poetry include Vida Briss, Austin Dobson, Edith Rutter, J. A. Coupland, J. W. H. Crossland, etc., etc. Published by Littell & Co., Boston.