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THE EARLY DIAGNOSIS OF HIP
DISEASE.*

BY W. J. GIBSON, M.D., OF BELLEVILLE.

The frequency of the occurrence of hip disease; the peculiar features it presents; the disastrous results, not only to the utility of the limb, but to life itself, which too frequently accompanies its progress, has given it an especial prominence among surgical diseases of the joints. Formerly it was thought to be dependent almost entirely upon scrofulous taint, and many authors still regard it as mainly of constitutional origin.

When we consider the period of life at which hip disease usually begins; the developmental process through which the osseous framework is progressing up to the age of puberty; the manifold accidents through which, in childhood, the hip joint is liable from falls, over-fatigue, exposure to wet and cold, or to direct injury, the natural conclusion is that the earliest cause is not so much due to constitutional taint as to local injury.

For purposes of diagnosis, the affection may be divided into acute and chronic; or if attention be directed to the structure in which it primarily begins, arthritic, acetabular, and femoral (Erichsen), or synovitic, femoral, and pelvic (Barwell). It is not always possible to accurately determine the exact seat of the primary inflammation. A discussion on this point would, however, be of more interest to pathologists.

Certain general phenomena which are usually associated with the disease might be mentioned, viz., pain, attitude, imperfect mobility, fixity of the joint, suppuration, sinuses, dislocation, and ankylosis. The four last mentioned are only to be found in advanced cases, and therefore are not pertinent to the present paper.*

In the acute form, the progress is so rapid that any attempt at exactness in tracing the local symptoms is well-nigh impossible. They differ but slightly from the general symptoms as manifested in acute synovitis and osteitis of other large joints. The anxious fear of the patient lest the limb should be disturbed; the flexion of the limb; the attitude of the little sufferer in grasping it for purposes of support or to prevent muscular tremors; the adduction and shortening; the intense suffering betrayed by the agonizing cries of the child, all point to rapidly progressive and probably destructive changes. The earlier stages of the disease are quickly passed through, and the third stage often reached in a few days.

In the chronic form, the symptoms are more insidious in their onset. For a considerable time a certain amount of lameness may be noticed, not at all constant, but more apparent after fatigue or unusual exercise. The lameness may disappear if rest be secured, but again recurs in a more marked and persistent form until a peculiar dragging of the limb takes place. The affected limb is never placed in advance, but always brought up slowly to the

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other, accompanied by inclination of the body to the unaffected side. As the weight comes on the unsound limb, it is quickly shifted to the sound side. After a period of rest, the lameness and limping in part disappear. Although the lameness is not entirely due to pain, but rather to a dread that putting weight on the affected limb may cause pain, it must be borne in mind that the presence or absence of pain is probably in large measure due to the fact that the seat of the primary inflammation is not always in the same structure. If the patient be examined when resting, especially if lying down, it will be observed that although the general attitude of the body may differ in different cases, the leg will be *flexed* in all cases. If questioned as to the seat of pain, intelligent children will refer it to the knee; it may be to a well-defined spot on the inner aspect of the knee, or all around it. Not infrequently the pain is located on the inner side of the thigh, at the apex of Scarpa's triangle. The distribution of the obturator and anterior crural nerves will account for the pain in these regions, and yet it has been demonstrated that pressure on the exposed head of the femur will cause pain to be felt at the knee alone. Careful manipulation at this stage may reveal slight thickening behind the trochanter major and within the groin. Doubtful as the foregoing symptoms may be as to the precise nature of the trouble, if, in addition, there be found a certain *fixity* of the joint, there can be no question that we have to deal with hip disease.

Too much care and gentleness cannot be exercised in manipulating the limb for the purpose of ascertaining the presence or absence of fixity of the joint. With the patient stripped and lying on the back on a firm mattress or table, a casual examination of the foot, ankle, and knee will secure the confidence of the child. The unaffected limb may be examined by lifting it from the mattress to a position at right angles to the body. The same manœuvre may be tried with the affected limb, and while doing so be careful to observe whether the pelvis remains quiet or moves with the limb. Placing the affected limb flat on the mattress, observe whether the loins are in contact with the mattress or are arched upwards. Again taking the sound limb below the knee, flex the

leg on the thigh, the thigh on the abdomen, adduct, abduct, and rotate the limb, all the time watching the pelvis, which will be observed to be quiet, or nearly so. Taking the unsound limb, repeat the same manœuvres, and it will be seen that the pelvis moves with each motion of the limb, while the head of the femur lies quiet in the acetabulum. This method (Barwell's) will elicit the very earliest sign of disease in the joint.

In the second stage of the malady there are certain "posture symptoms" which are regarded as diagnostic of the affection, though they must not be taken as the only phenomena present at this stage. These symptoms are lengthening or shortening of the limb, on which great stress is laid by some authors as being characteristic of hip disease. When such symptoms are present at an early stage, careful investigation will reveal the fact that they are only apparent, not real, and are dependent on inclination of the pelvis, and are not to be regarded as early indications of the disease. When such symptoms become so marked as to be easily recognizable, the disease has already reached an advanced stage.

To determine whether lengthening exists, let the patient stand with back to the surgeon, clothes raised above the waist. The patient will now stand on the sound foot, with the other in advance, and resting sometimes on the sole, but usually on the toes, with knee bent. There will also be noticed some lateral separation of the limbs, and any attempt at change of position causes him to lose his balance in the endeavor to avoid putting weight on the affected limb without altering the angle between the femur and the innominate bone. It will further be observed that the crest of the ilium is lower on the affected side, and that the spine assumes a curve, with the convexity towards the affected side. Another important symptom characteristic of the disease at this stage is *flexion* due to rigidity of the muscles, the psoas, iliacus, and adductors being in a state of great tension. Wasting of the limb now begins, the pains are more intense and somewhat different in character, and are described as "starting pains." Tumefaction, or swelling, is also a feature of this stage, and is usually preceded by a regular and continuous rise of temperature, which

points to the probable commencement of sup-
puration followed by rapid disorganization of
the joint.

THE EXPECTANT TREATMENT OF HIP-JOINT DISEASE.

BY DR. BINGHAM.

Mr. President and Gentlemen:

So much has been written upon this subject of late years that one finds it difficult to record observations that may not appear trite to the observant members of the profession; and it would doubtless have been wiser had your committee selected for the task of preparing this paper some more ardent admirer of the expectant plan of treatment. The younger surgeons, more particularly, are perhaps too liable to chafe at the restraints and uncertainties of what must inevitably be a prolonged course of mechanical treatment, and elect rather by an immediate radical operation to arrive at what they consider to be equally good results. And I am free to confess that from a careful study of pathology of the condition, and a somewhat limited experience and observation, my own inclinations have been in favor of early and radical interference. This tendency is doubtless encouraged by the immediate and great success which often attends the efforts of the excisionist. This is well illustrated by such cases as that of Harry C., at present under my care at the Victoria Hospital. For more than a year he was hobbled by splints and crutches, leading a miserable and painful life. On April he came into my clinic, owing to an abscess which was pointing half-way down the thigh on the outer surface. I found the abscess communicating with the hip-joint and excised the badly impaired joint on April . . . Immediate results: Normal temperature, invigorating sleep, freedom from pain, healing by first intention; and on May 11th he is trotting about the ward quite comfortably. But one cannot forget that such a case must not yet be pronounced permanently cured, and an occasional death from tubercular meningitis or pulmonary phthisis rapidly following an operation is apt to dampen one's ardor. And I would recommend every surgeon who has believed that the true solution of the problem lies

in the use of the knife to study carefully the record of such men as Lewis, Sayre, or Lovett and Shaffer. The former has recorded 407 cases treated by mechanical methods; of these 301 are cured (*viz.*, 71 with perfect motion, 142 good motion, 83 limited motion, and 5 ankylosed); under treatment 14, abandoned treatment 3, discharged 2, unknown 78, died 9.

On the other hand, Poore, of New York, has reported in April of this year 66 cases of excision, as follows: 32 cured, 25 died, 3 discharged relieved, 2 not improved, 4 in hospital.

These results are interesting, if not very encouraging, to us as surgeons, and, while I decline to accept them as indicating the average results obtained, they should warn us as searchers after truth to refrain from bigotry in method or observation. One great difficulty is that the majority of these cases occurring, as they do, among the poorer classes do not seek surgical assistance until the inroads of the disease are far advanced, when mere mechanical treatment is in the opinion of many no longer indicated. But let us suppose that we are fortunate enough to see the case in the earliest stage of the disease, I presume there is not one of us who would not give the expectant plan of treatment a careful trial before proceeding to radical measures. This first stage may almost invariably be diagnosed by the careful observer. Usually there is some abduction (or there may be adduction) of the limb with external rotation, and perhaps some flexion. The pain, which is very variable, may be wholly referred to the knee or along the thigh. But perhaps the most important symptom at this early period is the spasmodic contraction of the muscles around the joint, which is to be very well seen upon extreme external rotation and abduction. And this reflex muscular spasm should sound for us the keynote of our treatment of the early stage. It is the effort of nature to protect the joint and to maintain the head of the femur as far as possible immovable in one position until the inflammation subsides. Let us imitate nature, then, in so far as absolute fixation and protection of the joint are concerned. But let us go farther, and by *traction* secure immunity from irritation to the diseased head by pressure on the acetabulum. In pursuance of this method, then, the patient should be confined to bed. A long

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straight splint is applied from axilla to ankle on the sound side, and to the affected limb longitudinal extension is applied by weight and pulley, at first in the direction of the deformity, gradually changing the direction of the force applied until the limb is parallel with its fellow. In addition, another force is applied transversely by fastening a loose bandage around the upper third of the thigh, to which a cord is attached and a weight hung over the edge of the bed. Thus traction is applied in two directions, first in the long axis of the limb, and secondly in the direction of the long axis of the neck of the femur. This transverse or obliquely transverse force, as you will observe, is directly opposed to the powerful adductors and glutei which drag the head upward and inward against the acetabulum. The joint is thus rendered perfectly immovable, and at the same time the health of the patient is built up in every possible way with pure air, nutritious diet, etc. We have now placed the child in the best possible position to combat the early inroads of the disease.

But here at least two questions will be encountered.

(1) Even in the early stage of the disease, would not the patient be better up and about with a properly adjusted splint?

(2) As a result of this absolute fixation, which may have to be prolonged, will not ankylosis be sure to occur?

Both questions may be answered in the negative.

In reference to question (1), I would say that absolute rest to the joint is a prime necessity. We are dealing with a disease which possesses some of the essentials of malignancy, especially where any irritation co-exists; therefore, I would avoid even the possibility of irritation by maintaining the recumbent position until any acute symptoms have *completely* subsided.

It is true we are told that in many of these cases in the early stage the bacilli are frequently absent; this can only be relatively correct.

In a tuberculous patient the bacilli are present somewhere in the body, and the simplest form of inflammation of the hip-joint, the result of some trifling traumatism, will quickly become the rallying point of the disease germs. Let us treat it, then, from the beginning as though the bacilli were really present in the inflamed centre.

In answer to the second question, Phelps, of New York, has demonstrated by experiments upon dogs that absolute fixation of a healthy joint does not produce ankylosis even at the end of five months. It is the prolonged severity of the inflammatory process, not the mere immobility, that produces ankylosis. But even should bony ankylosis result, what is this compared with the saving of the patient's life?

How long are we justified in the continuance of this treatment of fixation and traction with the patient in the horizontal position?

That depends upon the conduct of the disease and the general health of the patient. Perhaps two weeks, perhaps two months. Either one of two courses will the disease pursue. Either the deformity, inflammation, and pain, and all symptoms of disease will gradually subside (that is, pathologically speaking, the tuberculous nidus will return to a quiescent condition and be rendered comparatively harmless by an encapsulating area of healthy bone more or less consolidated); or, on the other hand, the disease will gradually progress. It is highly essential that we should be able to ascertain which of these courses is being taken by the disease; and it is equally important that such knowledge be arrived at without inflicting undue violence upon the joint by rough manipulation on the part of the examiner.

We recognize the fact that the history of these cases almost invariably begins with some petty traumatism, which nevertheless proved sufficient to light up the disease; and yet, in the face of this fact, do we not sometimes see the examining surgeon, in his efforts to ascertain the progress of the disease, violently extending and rotating the limb, even calling anæsthesia to his aid in order that the protesting voice of nature may not interfere with his energetic manipulations?

The extension, then, should be removed from time to time, and the limb and joint *carefully* examined with the least possible violence.

In the more favorable event we will find the deformity or distortion has appeared, and the limb will be parallel with its fellow; pain on motion and tenderness on pressure will be absent or much reduced, little or no thickening in the joint will be felt, and the ilio-femoral crease will be defined. Some apparent lengthening

may be present owing to the persistent tilting of the pelvis, the functions of the joint will be fairly restored, but external rotation will still be imperfect owing to the continued spasm of the muscles.

Now with this condition of things present we are justified in immediately discarding the extension weights, carefully adjusting a long traction and fixation splint, and with the aid of a pair of crutches and a high boot on the sound leg getting the patient about the ward and into the open air. While the patient progresses favorably this complete fixation and traction should be maintained if necessary for a prolonged period, which should not be shortened by the dread of ankylosis, but should only be terminated by the cure of the disease. In reference to the form of splint to be used, that belongs rather to the paper read by Dr. McKay, who has discussed the mechanical treatment. I will simply say that the ideal splint aims at absolute fixation of the joint with prevention of pressure upon the femoral head or the acetabulum, and these objects appear to be fairly well attained by the splint recommended by Phelps, of New York, in the *Medical News* of Dec. 16th, 1891. It may be removed at night and the extension weight reapplied.

Now in reference to the more unfavorable event, viz., when in spite of your early treatment in the recumbent position, the disease gradually extends. This unfortunate fact may be ascertained by the increasing pain on motion and tenderness on pressure, possibly apparent shortening with adduction; the ilio-femoral crease may be lost or ill-defined, thickening may be felt in the joint or in the neighborhood of the great trochanter; should the disease be sufficiently advanced, fluctuation may be made out and abscesses may be pointing around the joint or down the thigh under the tensor fasciæ femoris muscle. In this condition of advancing disease, with my present light of personal experience and observation, expectant treatment must now terminate and resort be had to the knife. Remembering the pathological condition present, I believe the dangers of absorption have now become so great as to seriously imperil the patient's life and to necessitate the complete removal of the diseased product.

I am aware of the wonderfully encouraging

statistics recorded by American surgeons of late years in the mechanical treatment of these more advanced cases, but I cannot help viewing the condition of these mechanically "cured" cases as, to say the least of it, precarious. Surely we must admit that the tubercle is still present, though encapsuled and quiescent, yet capable of rekindling the inflammatory process when irritated by traumatism. Shaffer, of Boston (and who is more conservative than he?), admits that he has seen many cases of relapse in six and eight years, and even sixteen years, after apparent cure by mechanical fixation methods.

Should we, however, for any reason be obliged to continue expectant treatment after caseation has taken place, the patient if about should at once be returned to bed, abscesses opened aseptically, the cavities washed out with H_2O_2 and stuffed with iodoformized gauze, and weight extension reapplied. In spite of all this, should suppuration continue and the patient's health begin to give way, there is certainly no longer any excuse for delaying the radical operation; and very probably you will afterwards regret you had not resorted to excision at an earlier period of the disease.

In this brief paper, I have confined myself to hip disease as seen in children or youths, because it is in these cases that the element of doubt as to treatment is largely centred.

I have had in view particularly those cases in which the disease develops on or near the epiphyses of the bone, and not those cases of synovial origin so rare in childhood.

I have not taken into account the circumstances in the life of the patient which might preclude even a comparatively brief course of expectant treatment and might render it necessary to give him the benefit of immediate radical interference.

I have not referred to those cases of non-tubercular hip disease periostitic in origin, and following the continued fevers, more especially typhoid; nor have I included cases of congenital syphilis. I have refrained from quoting statistics largely because they are valuable to a certain degree only, and in the present state of our knowledge of the disease are often misleading.

INCLUSION.

(1) Hip-disease when seen in the early or

first stage is often amenable to mechanical treatment.

(2) Although in the early stage the bacilli may frequently be absent, the joint should be treated from the beginning as though they were invariably present.

(3) An important cause of the extension of the disease is the irritation due to pressure between head of femur and acetabulum.

(4) This is best prevented during the acute period by rest in bed with fixation of the body by a long splint to the sound side, and longitudinal and transverse extension by weights to the diseased joint.

(5) As soon as the early symptoms have quite subsided, the patient should be fitted with a long traction and fixation splint, and not allowed to rest for one moment on the diseased joint until completely cured.

(6) After indications of softening have become apparent and persistent, expectant treatment is no longer indicated.

BIOGRAPHY.

Bradford and Lovett—*Orthopedic Surgery*.

Phelps—*Philadelphia Medical News*, Dec. 26, 1891.

Gillette—*Philadelphia Medical News*, July 11, 1891.

Poore—*N. Y. Medical Journal*, April 23, 1892.

Sayre—*N. Y. Medical Journal*, April 30, 1892.

Gibney—*Boston M. & S. Journal*, vol. 125, pp. 613, et seq.

Lovett and Shaffer—*N. Y. Medical Journal*, vol. 54, pp. 33, 141, 594.

Judson—*Journal of American Medical Association*. April 11, 1891.

Treves—*Manual of Surgery*.

THE OPERATIVE TREATMENT OF HIP-JOINT DISEASE.*

BY A. PRIMROSE, M.B., C.M. EDIN., M.R.C.S. ENG.,
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Extreme views are at present advanced—on the one hand, by enthusiastic advocates of the expectant method of treatment, and, on the other, by surgeons who, with equal enthusiasm, advance views in favor of operation at an early stage in the disease. It is impossible to form

a fair judgment with our limited amount of experience, and with very little of statistical value. We must remember that the operation of hip-excision is one which has of late years become greatly modified. The technique of the operation has been completely changed, and the large mortality formerly resulting from the operation has been reduced in early cases to five per cent. Wright, of Manchester, has a still better record, having operated in over one hundred cases with only three deaths.

It is held that in the vast majority of cases which are submitted to early operation the course of the disease is cut short very materially; on the other hand, under expectant treatment, our patients may be doomed to a lengthened period of illness—two or three years would not be considered unusual. If, therefore, we can submit our patients to an operative procedure which is to effect a comparatively early cure, we are perfectly justified in doing so. It is our duty to investigate the question, and if we find that we can rid the patient entirely of a disease which is likely to run a prolonged course, then we should not hesitate to give the sufferers from hip-joint trouble the great benefit which may be derived from modern methods of dealing with such cases by operation. Statistics are not as yet available to prove our ground; we cannot say absolutely in a given case that we can terminate the disease in so many weeks or months. This result is undoubtedly obtained in many cases, but not in all. Then, again, the danger of recurrence seems to exist after operative procedure as well as after apparent cure from expectant treatment. It would appear that better results as to function of the joint are obtained after treatment by rest than after operation. Concerning the results after operation, the only definite statement that one can find is that of Sir William MacCormack, who states that one-half of successful cases walk without a stick; the other half require the aid of a stick in walking.

An error in judgment is often made in considering the advantages of operative procedure, by taking the results of operation at all stages of the disease and comparing them with the results of treatment by rest. Now the most ardent advocates of operative procedure

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only recommend such methods in the early stage of the disease; on the other hand, those surgeons who can see nothing good in early operations are fond of citing the cases which have been subjected to operation at all stages of the disease. The statistics thus produced are of necessity very misleading; they include many cases which have been subjected to expectant treatment for a lengthened period, and then operated upon as a last resource. This is of course eminently unfair. We must remember that the question at present is only concerning the disease in its early stage. At certain stages of the disease we find most surgeons of one opinion as to the proper course to pursue; thus, given a large abscess in connection with the joint, with constitutional symptoms, the result of pyæmic absorption, with pain and emaciation, and we find that few surgeons would refuse to open the abscess and remove diseased tissue. In considering the question of operation in hip-joint disease, therefore, we must confine our attention to the question as it affects early cases, and we must not be influenced by the misleading statements made by those who are forever harping upon the dire results of operative procedures, pointing to patients who have been the victims of injudicious treatment by retentive apparatus until the disease has advanced to such an extent that their only hope lies in operation. These cases often do badly, and we would be surprised if it were otherwise. We find, among British authorities, that Barker considers operative procedure legitimate only in the early stages; whilst Marsh, who is an advocate of conservative treatment, seems to think that such measures are only justifiable in the late stages of the disease.

Let us consider for a moment what may be accomplished by operation in an early stage of hip-joint disease. It is possible for us to submit our patient to an operation which is attended with very little risk to life, and we may be able to remove entirely the disease in the articulation. Further, if the disease be restricted to a small area it may be possible for us to operate through comparatively healthy tissue, or at most through tissue which is the seat of a non-infective inflammation (which is attendant upon and surrounds the tubercular deposit); we may reasonably hope for healing by first intention, and, having ac-

complished this, we keep our patient at rest. Surely, under such conditions, the sufferer is in a better condition for speedy cure than would be the case if we trusted to rest alone, without any attempt to eradicate the tubercular deposit which is the cause of the whole trouble. The operation, therefore, in early cases is advocated on good, sound surgical principles, and the results obtained so far are most encouraging. Of course we would expect a better result the earlier the disease is detected and the operation performed.

The resulting deformity after operation is not greater (probably not as great) as after treatment by prolonged rest in splints. The amount of shortening is inconsiderable; this is accounted for by the fact that the growth, in length, of the femur takes place chiefly at the lower epiphysis. Then, again, in long-standing cases of hip disease without operation we have a considerable amount of atrophy of bone going on, due more particularly to continued pressure; the bone is the seat of a rarefying osteitis, and the contraction of muscles about the articulation keeps the articular surfaces constantly pressed against one another, and, as a result, atrophy and shortening takes place. As to the age for operation, we must remember that the operation is much more formidable in very young infants and in adults than it is between the ages of, say, 5 and 16. Many surgeons will not excise the joint in the adult.

The methods of excising the hip-joint are numerous. The older methods by external incision are well known, and it is not necessary to describe them in detail. These operations are comparatively easy to perform, but the great objections to them are that the function of the joint is much interfered with by detaching the muscles attached to the great trochanter; then, again, the head of the bone is forcibly dislocated and made to project from the wound before the neck is sawn through. This procedure entails rough handling of the diseased tissue, which is unnecessarily broken up, and infected material may in this way contaminate the healthy raw surfaces of our wound. Operation by anterior incision is much to be preferred; the earlier operation of this kind was that suggested by Lücke. An incision $\frac{1}{2}$ inch below and internal to the anterior superior iliac

spine was carried downwards and inwards in the line of the axis of the femur. This incision passed down internal to the sartorius muscle and ran parallel to the anterior crural nerve; the anterior capsular ligament was opened up and the neck of the bone reached and divided. The objection to this method is that the strong ilio-femoral band is greatly cut up; it is so thick that it is often necessary to divide some of the fibres transversely; this important element in the strength of the joint is damaged to a considerable extent and the integrity of the joint is impaired. Again, the incision is so nearly over the head of the bone that, if the disease prove to have involved the neck extensively, or the trochanter, it is impossible to remove it.

Barker's method of excising the hip by anterior incision is the best procedure. His incision begins $\frac{1}{2}$ inch below and external to the anterior superior spine, and is carried down 3 or 4 inches in the axis of the limb. The incision is carried boldly down to the bone, passing between the sartorius and rectus muscles on the inner side, and the tensor fasciæ femoris and the glutei muscles on the outer side. The anterior capsular ligament is opened up and the articulation exposed; the neck of the bone is then divided by means of a narrow-bladed Adam's saw, and the head and neck removed. The acetabulum may be explored, and if diseased tissue be found there it should be removed, and the soft parts of the articulation should be similarly treated. For this purpose the use of Barker's flushing scoop is valuable. It combines the advantages of a Volkmann's spoon (and is shaped like it) and an irrigator at the same time. The scoop is hollow, and allows a stream of boiled warm water (temperature 105° to 110° F.) to flow through it; thus, as the diseased tissue is detached it is flushed out of the wound. In many cases the wound may be closed by suture without a drainage tube. This method of operation gives free access to the joint, there are no muscular attachments disturbed, the ligamentous strength of the joint is not impaired, and the diseased tissue is removed entire with as little breaking up as possible. It may be thought advisable to drain the wound cavity; this is particularly needful in those cases in which extensive disease is found with suppuration. It has been urged

that drainage is necessarily inefficient from an anterior wound. It is very easy to overcome this objection, however; thus, after excision by the anterior method, a pair of sinus forceps may be thrust through the posterior capsular ligament, close behind the trochanter, and the point of the forceps may be cut down upon from behind; a drainage tube may then be placed in position and the wound cavity thus drained from a dependent posterior opening.

A question of considerable importance in excising tubercular bone is with regard to the amount of bone to be removed. We cannot always judge accurately by microscopic examination as to the precise limit of the tubercular disease. We must remember that a very small tubercular focus may be surrounded by a very large area of inflammatory products of a non-infective character. Thus we find rarefying osteitis accompanying the tubercular process. We may find very extensive bone atrophy; this bone, however, may possibly recover if we remove the primary cause of the trouble in excising the tubercular disease. It is very common practice, when advanced atrophy of the bone is found, to proceed to amputation. This is more particularly the case in diseased articulations other than the hip. The question which ought to be settled is whether or not it is necessary to remove all the bone which is the seat of rarefying osteitis. We are inclined to believe that such bone is not necessarily beyond hope of recovery. It is a point which has not, as far we are aware, been discussed. In settling it one would have to decide not only the possibility of restoration of such inflamed bone, but one would have to find some means of distinguishing between tubercular tissue and tissue the seat of a non-infective inflammation.

ANTIKAMNIA.—Dr. Caleb Lyon, of Rossville, Staten Island, thus speaks of antikamnia: I reiterate my assertions made nearly a year ago, and am daily prescribing antikamnia with happiest effects. In my practice it accompanies the maid from her virgin couch to her lying-in chamber, assuaging the perplexities of maidenhood and easing the trials of maternity with most gratifying results. I earnestly hope that the proprietors of this valuable remedial agent will keep it up to its present standard of purity and excellence

HIP-JOINT DISEASE—THE MECHANICAL TREATMENT BEFORE AND AFTER OPERATION.*

BY DR. A. M'KAY, INGERSOLL, ONT.

As it is not a part of my duty to discuss the merits or demerits of the purely mechanical as opposed to the immediate and heroic measure of removing all diseased tissues infected by tubercular deposit, but to confine my remarks only to some of the appliances in use at the present time, this paper will claim one essential merit, viz., that of brevity.

In looking over recent literature on the subject, one cannot help admiring the inventive faculties of some of our surgeons, as well as the admirable skill displayed in securing modifications to meet their own ideas on the subject. Fortunately for the general practitioner, however, we now have a considerable number of appliances to select from, and it should not be forgotten that the successful treatment will often depend on a proper selection of an instrument. As it is now admitted that the amount of force to be applied will vary with the circumstances, it should at least meet the following requirements, viz., relieve muscular tension, secure immobility of the joint, allow of extension and counter-extension if required, and permit the patient to have plenty of sunlight and out-of-door exercise. During the first stage of the disease, should the symptoms be acute, extension by means of a weight and pulley will secure (by giving complete rest to the body) a more rapid control of the inflammation in the joint, and prepare the limb for the apparatus to be applied later on.

The most convenient method is by a single strip of plaster, commencing at the internal and upper portion of the thigh, passing under the sole of the foot and up the outside of the leg to the great trochanter to be covered by a bandage. Where the little patients are very restless, sand bags will often answer better than the long body splint for the purpose of keeping them quiet.

Flament, of Lille, reports the successful treatment of cases by means of continuous extension with an immobilization apparatus attached to a portable bed, so as to allow sunlight and

fresh air. About the only essential difference between the various instruments is in the matter of extension.

Mr. Thomas, of Liverpool, desiring complete immobility of the hip joint, uses a posterior splint composed of an upright strip of soft iron reaching from the level of the angle of the scapula to below the middle of the calf, and bent so as to fit the incurvature of the loins. To this is attached three bands, the first at the top, the second above the knee, and the third embraces the leg. A thick sole is worn on the shoe of the sound foot, so as to allow of extension by the weight of the limb. The objections to this splint would appear to be insufficient extension, and the difficulty in managing the patients owing to the absence of a joint at the knee.

The results, according to Dr. Huddleston, of Boston, are not very encouraging. Of 14 cases treated with the Thomas splint in the Children's Hospital 9 had abscesses; 9 had elevation of trochanter above Nelaton's line; 11 had atrophy of the thigh of over two inches; 5 had five degrees of adduction; 8 had some flexion; 6 had no motion at joint; 4 had motion of only a few degrees; 3 had good motion; 1 had perfect motion; and 6 were brought into the hospital for correction of deformity or relief of pain. Results: Good position, little flexion and adduction, great shortening, great atrophy, large number of abscesses.

The Sayer splint may be taken as an example of the other variety, allowing of extension by means of adhesive plaster attached to the lower band of the instrument and thigh, and counter extension by means of a perineal band attached to the other end. An extension bar at the side adjusts the amount of pressure.

I have had good results in three cases treated by a modified Sayer splint, having, instead of a ball and socket joint, a flat, stiff joint and an iron band around the hips. The side bar has a screw extension instead of the ratchet.

The mechanical treatment after operation, for from three to nine weeks, will be the same as for fractured thigh, with a certain amount of abduction, so as to prevent the end of the bone pressing on the wound, and extension by means of weights and pulley. After the wound has healed sufficiently, either of the splints referred to can be employed.

*Read before the Ontario Medical Association, June 2nd, 1892.

A CASE OF SENILE GANGRENE.

BY H. J. SAUNDERS, M.D., KINGSTON.

The following case of senile gangrene, in which amputation was successfully performed, is, I think, interesting and worth recording on account both of the age of the patient and the unpromising appearance presented by the vessels and tissues in the neighborhood of the operation, which made the chance of healing look very hopeless.

E.G., æt. 77, a retired farmer, very stout, weighing about 300 pounds, whose heart and large vessels were evidently in a state of atheromatous degeneration, was attacked with "grippe" on January 7th. He suffered severely, having frequent attacks of syncope, and his pulse was at all times feeble and irregular. On February 12th he complained of intense pain in the heel of the left foot, which on examination appeared waxy-looking and bloodless; a few days later the toes and instep became waxy-looking and livid, and the heel was black and shrunken; a few days later a gangrenous patch appeared on the instep and on the outside of the leg. This progressed till, some weeks later, sloughs separated in each of the three situations; that on the side of the leg first, exposing the peronei tendons and muscles; next, that on the instep; and, lastly, that on the heel, leaving the insertion of the tendon Achilles bare. His general condition at this time was exceedingly unfavorable; the pain was intense, and only relieved by large and frequent hypodermic injections of morphia, as well as by taking it internally; constant diarrhœa persisted, resisting all treatment; the stomach was unable to retain any food except small quantities of milk, and the weakness and irregularity of the heart were such that syncope occurred if the patient were raised to the sitting position. Under such circumstances death seemed inevitable, and not likely to be postponed for more than a few days, or weeks at the furthest, and I deemed it useless to attempt to do more than to relieve his suffering as much as possible. Nevertheless he lingered on, contrary to my expectation, till the following May, without any material change. At this time his condition was so distressing from the constant pain and the discharge and effluvia from the

gangrenous extremity, that, after consultation with Drs. Fenwick and Garrett, I decided, with the consent of his family, to risk the removal of the limb. Accordingly, with their assistance, on May 17th, I amputated the leg above the knee. Hardly any trace of muscular structure was observable, all the tissues being in a state of fatty degeneration. Both the popliteal artery and vein were rigid and filled with black solid clot, and projected from the amputated surface like two fingers. The other vessels were very small and insignificant, and the hemorrhage altogether was so trifling that it seemed doubtful whether there were sufficient circulation to maintain the vitality of the flaps. Notwithstanding the apparently unfavorable condition, union took place by first intention. With the removal of the limb the pain subsided, and within a fortnight we were able to reduce the daily amount of morphia from four or five grains to half a grain, and at the end of that time to discontinue it altogether. The patient's health has steadily improved, and at the present date (Aug. 31st) his appetite is good and he is comfortable and free from pain. Owing to the condition of the heart he is unable to sit up, each attempt to assume the erect sitting position being followed by syncope. An additional hindrance to sitting up is also presented by the condition of the right hip, which is partially ankylosed, the result of a fracture of the neck of the femur received many years ago. I may add that the anæsthetic used was a mixture of chloroform 1 part, and ether 2 parts, administered in Clover's inhaler, and that it was borne well and not followed by any unpleasant after-effects. Some retraction of the tissues took place a few weeks after the operation and threatened unpleasant results, but was overcome by longitudinal straps of adhesive plaster, to the loops of which a flat iron was attached and hung over the end of the bed, so as to keep up moderate extension. This was continued for three or four weeks, when it was found no longer necessary.

THE NEW YORK PHYSICIANS' MUTUAL AID ASSOCIATION is now able to pay \$1,000 upon the death of a member, which is the full amount allowed under the by-laws. At present the number of members upon the roll is 1,106.

Selections.

THE MANAGEMENT OF ECZEMA IN INFANTS AND YOUNG CHILDREN.

Clinical Lecture delivered at the Philadelphia Polyclinic

BY ARTHUR VAN HARLINGEN, M.D.,

Professor of Dermatology in the Philadelphia Polyclinic

GENTLEMEN,—The subject of eczema in infants and its treatment is one upon which I have had occasion to write and speak many times in the course of twenty years of the practice and teaching of dermatology, and I sometimes think that the theme is a little worn. But I have still reason to believe that all practitioners are not as fully able to cope with these cases as they would like to be; and, besides this, new students and young practitioners are constantly coming forward who require to be instructed upon some of these special points, which are not much dwelt upon in the course of medical training in our colleges. And, yet, among the first cases the young practitioner encounters are those of the various diseases and ailments of childhood.

Eczema cannot be named among the more serious diseases, but still you may meet cases at any time which will try your patience and baffle your therapeutic skill, and which, by the amount of suffering and sleeplessness caused the little patient and the worry and loss of rest to the parents and attendants, will sometimes rise to the proportions of a domestic calamity.

The infantile skin being particularly susceptible to external injury and irritation, it is not uncommon to see the milder forms of eczema spring up suddenly as a result of too much soap and water, of wet diapers, of slobbering about the neck, or merely from the rubbing and chafing of irritating clothing or exposure to the rigor of winter air in taking exercise.

The erythematous form of eczema here understood is characterized by a simple redness of the skin without infiltration, moisture, or discharge of any kind. It is not apt to be mistaken for any other disease, unless under exceptional circumstances, which I will mention in a few moments.

It is very easy for this condition, occurring in the tender skin of infancy, to run into another and more serious form of eczema, ac-

companied by exudation and maceration of the cuticle, or the formation of vesicles, and for this reason it should be checked at once. As it is almost invariably due to local irritation, the cause of this must be looked for, and so far as possible done away with.

One of the commonest forms of erythematous eczema in infants is that often called intertrigo, and which is here due to the maceration of the buttocks, groins, and thighs in the urinary and fecal discharges retained in the child's napkin or diaper. When these discharges are normal they are rarely irritating, but an attack of indigestion or diarrhoea gives them an irritative character, and if the condition remains unchanged intertrigo and erythema supervene, and the condition soon goes on to the stage of moist eczema, usually beginning in the groins.

The appearance, which is at first only that of a more or less dusky redness of the skin, soon changes, and fissures occur in the folds of the groins and about the genitals and anus, the perspiratory secretion becomes rancid, and adds to the irritation and extreme discomfort, due to burning and itching, and pain on movement results.

In these cases the first thing to be done is to change the character of the alvine and urinary discharges. The feces are apt to be white and curdy, and very sour-smelling. Give minute doses of calomel and soda, sometimes adding a little rhubarb, and correct any possible errors in the infant's dietary, and you will soon find a change, not only in the character of the stools, but also in the urine. The latter, which is frequently somewhat scanty, highly colored, and acid, with occasionally some deposit of urates, becomes changed by the rectification of the intestinal disturbance.

Meantime you must protect the tender skin from the irritating fluids in which it is constantly bathed. Ointments and greasy applications will not usually suit, because they quickly become irritative. A careful cleansing of the skin with some mild soap and warm water, followed by careful drying with a soft towel and a coat of vaseline, is very effective in giving relief.

The proper soap for use in these cases is one as nearly neutral as possible. Almost all soaps used in washing infants are too alkaline. Even the finest castile soap is not satisfactory. I have lately employed a German soap invented

by Dr. Unna, of Hamburg. It is called "*Basis seife*," and is carefully made so as to be nearly neutral as compatible with the formation of suds in warm water. It is called "superfatted," but I think that is a misnomer.

If the eczematous condition requires local medication, a very mild astringent lotion acts better than other forms of treatment in most cases. The black wash of the Pharmacopœia, alone or with an equal quantity of lime-water, sopped on the skin or applied on soft rags in the folds of the skin from time to time, often acts surprisingly well. Powders are so apt to cake and crust that they must be employed with caution, and those containing starch should be avoided. Very finely-powdered talc, Fuller's earth, or, in some cases, the sub-nitrate of bismuth, are among the best.

When there are cracks and fissures, ointments may sometimes be used. The black wash, followed by an ointment of oxide of zinc and vaseline in equal parts, may be applied in small quantity. Now and then an ointment of sub-nitrate of bismuth, half a drachm to the ounce of vaseline, may be employed.

The same principle applies in the treatment of erythematous eczema about the neck, etc., only that no internal treatment of any kind is required in these cases.

I have said that the diagnosis of erythematous eczema in infants presents no difficulty. The only exception to this is met with occasionally in certain cases of eczema about the buttocks. Here, when there is a tendency to infiltration resembling rather papular erythema than eczema, a case will occasionally be encountered which resembles one of the erythematous forms of infantile syphilis.

The syphilitic eruption, however, is almost always accompanied by moist papules about the anus, and you will also be apt to find some other sign of syphilitic infection, notably that nasal catarrh commonly called "the snuffles." In suspicious cases a very close examination should be made to exclude the more serious constitutional disease.

Erythematous eczema is a disease of earlier infancy. After the first six months of extra-uterine life the commonest forms are eczema *vesiculosum* and eczema *rubrum*.

A little before the advent of the first teeth,

children sometimes begin to show a slight redness in the cheeks, with the formation of incomplete vesicles. Often this does not extend beyond a small patch, which may come and go in sympathy with stomachal or buccal irritation. At other times the disease spreads rapidly, the cheeks and forehead become covered with a bright red, dry, or moist eruption, with a greater or less amount of exudation and crusting.

If the infant is badly nourished, or sometimes even when the general health is not perceptibly impaired, this eruption may spread and cover the whole head, and patches may appear elsewhere on the body and on the limbs. These are usually accompanied by much itching and irritation; the child weeps, struggles, and attempts to scratch and rub the irritated skin with fury. It seems to sleep little and cries constantly, depriving its attendants of rest, and demanding all the skill and solicitude of the physician to give relief. I need not dwell upon the picture, as it is, unfortunately, not an uncommon one.

In most of these cases the infant has had more or less digestive trouble. The cases I meet most commonly occur in children who have been brought up by artificial feeding. Your first efforts thus far are to be directed toward allaying any irritation which may be present in the alimentary canal. This is often no easy task. I cannot at present, however, go into this branch of treatment, which also you must naturally be prepared to advise according to the circumstances of each case.

I will say, however, that when no particular indication for treatment presents itself, the administration of minute and frequently-repeated doses of calomel is often of the greatest service. The course should last for twenty-four or thirty-six hours, and should be repeated every five or seven days, or at the beginning of each recurrence.

When the eczema occurs a little later, about the end of the first year, the teeth are almost always at fault. A fresh recurrence of the eczema may be looked for just before the eruption of each tooth. The moment the teeth appear through the gum, the eczema tends to subside. You may aid nature by incisions over the pressing tooth, often with very great advantage.

In severe cases it is certainly better to put the patient under some form of restraint. It seems cruel to prevent the little sufferer gaining any relief by rubbing and scratching. No one who has experienced the agony of itching would desire to restrain himself from the relief of scratching, temporary though such relief must be, and almost always followed by an increase in the inflammatory symptoms.

But in the case of infants the restraint should always be accompanied by thorough and careful application of remedies calculated not only to relieve the inflammatory symptoms, but also to assuage the pruritus.

It is the custom to use ointments of oxide of zinc, but these are so adherent that, on the scalp at least, they are inconvenient. Ointments of some sort, however, are suitable for this form of eczema, and it is generally best to use vaseline as a base, although adreps may be substituted. Lanolin is so tenacious that it should not be used, except in combination with vaseline. One part of lanolin to four of vaseline makes a convenient excipient for whatever medication may be employed.

In those somewhat unusual cases where there seems to be little or no pruritus, an ointment of boric acid (twenty or thirty grains to the ounce) may be prescribed. In other cases a drachm of sub-nitrate of bismuth to the ounce of ointment is of use. These ointments are best applied spread on linen rags or on strips of paraffin paper. They should be cleaned off from time to time by the use of warm water and the "*basis seife*," mentioned above, because decomposition and irritation soon occur under such dressings.

In practice you will find it extremely difficult to have the head and face kept covered with dressings of any kind. The constant movements of the infant render it next to impossible to keep bandages in place. I should advise you, when possible, to make such applications and dressings with your own hands. In this way a great deal will be learned about the necessary manipulations, and your early struggles will render you more charitable towards the attendant when you find that your carefully-given directions have not been complied with, and that, on a second visit, a few scattered smears of ointment amid the raw and

crusted area of diseased skin are the only evidence of any application having been made.

Curiously enough, one difficulty in making local applications in these cases comes from the reluctance of parents and attendants to "disfigure" their children by the application of bandages. It is a point of view I have never been able to take, that of regarding a swollen, red, crusted, weeping face and head, scarcely recognizable as human, in the light of a more agreeable object than the same parts covered with healing and beneficent applications.

Where there is pruritus, you would do well to have the various ointments employed rubbed gently into the skin in small quantities and at frequent intervals. The addition of from three to ten grains of carbolic acid to the ounce of ointments mentioned above will soothe the itching in most cases. Tar or oil of cade, in the proportion of a drachm to the ounce of ointment, is an excellent antipruritic; it is much more disfiguring than the carbolic acid, however.

An excellent preparation in this form of eczema is the following:

R--Sulphuri precipitat.,
Picis liquidæ, aa ʒss:
Ung. zinci oxidi, ʒi.—M.

Keeping in mind what I have said about the clinging properties of oxide of zinc ointment, you will not use this when there is much hair, but I know of no more generally useful ointment in these cases.

When the pruritic eczema is in the form of small patches, especially on the cheeks, and when the discharge is not very profuse, the following pigment is convenient:

Olei cadini, ʒi.
Collodii, fʒi.—M.

A camel's hair brush should be fastened to the cork so as to be withdrawn with it, and the attendant must be instructed to keep the bottle closed.

A coating of this pigment brushed over the diseased skin acts as an antipruritic, and also protects the diseased patch from the air and, to some extent, from the hands of the little patient. When the disease is on the cheeks, it is usually the most convenient application which can be made. The pigment stings slightly when first applied, but this discomfort passes away almost immediately. The child should

be held firmly to prevent struggling during the laying on of the pigment, and care should be taken to avoid getting too near the eyes.

You may think I have gone into these points with a good deal of unnecessary detail, but I can assure you that in this, as in so many other points of practice, strict and careful attention to details will alone give satisfactory results.

Older children often suffer from eczema, which may or may not have begun in infancy, and these cases, when chronic, are often very intractable, lasting all through childhood and even early youth, and sometimes hardly passing away at maturity. Scrofulous and ill-nourished children are very apt to suffer from vesicular and pustular eczema combined, or from the pustular form alone. In these cases tonics and nutrients are called for. Iron, cod-liver oil, extract of malt, and quinine may be employed from time to time.

Arsenic is a drug so commonly employed, even at this day, in the treatment of eczema of all kinds that you will naturally expect me to say something about it; but I must distinctly state, as the result of a very extensive experience in the use of this drug, that, in my opinion, it has no specific effect whatever upon the course of eczema, and that even as a tonic its use is limited. In children, disturbance of the digestion is frequently the most marked result of its administration, and through this the disease may be, and sometimes is, rendered worse.

There is a form of this protracted chronic eczema in children which occurs in those having an unnaturally dry skin; in fact, a tendency to the condition known as ichthyosis. Here you will be continually baffled in your efforts, even to subdue the eczematous symptoms, to say nothing of permanently curing the disease.

The local treatment, which in ordinary cases is based upon the same course described under the head of infantile eczema, must be supplemented in some cases, especially when the disease is extensive, and always when a general dry ichtyotic condition of the skin co-exists, by the frequent employment of baths.

These should be warm, and should be medicated by the addition of a quarter of a pound of ordinary washing soda and a pint of clear starch to thirty gallons of water. For a young child's bath, half of each of these proportions

should be employed. The patient should remain in the bath some time, and when taken out should be dried without rubbing, and the appropriate applications made, when the patient should be put to bed to avoid catching cold.

In some of the more chronic cases of eczema in children, when a few circumscribed, thickened, itchy patches extremely resistant to treatment represent the disease, it may sometimes be necessary to have recourse to strongly stimulant applications, with a view to excite enough reaction to carry off the infiltration. Tar in ointments of various strengths may be employed alone or combined with a mercurial ointment, as in the eczema of adults. Washes of potassa caustica, from five to twenty grains to the ounce, may be applied by means of a small swab-brushed over the surface. These applications should not be allowed to remain, but should be quickly washed off and followed by a soothing ointment. They should be applied cautiously at first, remembering the more delicate character of the child's skin.

Such are the principles of the management of eczema in children, and with these suggestions you will be able to give relief in all cases, and to cure a large majority.—*International Medical Magazine*.

A METHOD BETTER THAN SUSPENSION OF APPLYING A PLASTER JACKET.

BY RICHARD BARWELL, F.R.C.S.

The author states that he has for some years past ceased to employ suspension in kyphosis, and has straightened, as far as safety will permit, the patient's spine by a modification of his method of rachylisis, which used differently, has proved successful in lateral curvature; the force—viz., traction by a system of pulleys—being used while the patient is sitting. It is thus carried out in a case of dorsal kyphosis: The patient being closed in a skin-tight knitted vest, and, with the usual parts padded, sits on an ordinary office stool about two feet and a half high, between two opposing walls in which certain hooks, etc., are fixed as for rachylisis. A three-inch wide piece of webbing, with strong cords at each end, is secured to one of the back legs of the stool, and passing over the back of

the patient's thigh sufficiently tightly is also secured to the other back leg. A strip of moderately strong unbleached calico, broad according to the size of the patient, crosses the abdomen on and below the umbilicus. This in the position under consideration is designated "counter-traction band." By means of the cords at each end it is fixed at the proper degree of tension behind. A similar strip of calico passes across the back on a level with the point of greatest curve. This is the "traction-band." If the projection be very sharp and angular, it is well to make a slit, lengthwise as regards the belt, two or three inches long, so that one of the laps may lie above, the other below the most prominent vertebra; a cord secured to both ends of this forms the whole into a loop, into which is hitched the hook of the system of pulleys. These two strips of calico would always crumple up and run into ropes as soon as tension comes on them unless prevented, which is easily done by having at hand four strips of common soft wood a little longer than the belts are broad. They are to be placed outside the calico pretty close to the patient's body, one on each side, and into them through the belts, and just at their edges, are thrust surveyor's pins. Lastly, a one-inch-wide loop of webbing, properly padded, passes across the manubrium sterni under the axilla on each side, and is secured by a cord running through a single pulley at proper tension behind. This is termed the "lanyard." The surgeon begins by making very slight traction by means of the system of pulleys, observing if the tension of his other cords is correct, and places the spine in proper position; if not, it can easily be altered by means of the single pulleys through which the cords run. All being correct he increases the tension, and slips between the laps of both traction and counter-traction bands a board of wood, from ten to twelve inches long, in order to prevent lateral pressure on the thorax and abdomen. He now increases traction up to the desirable point, recollecting that the Astley Cooper system of pulleys multiplies his manual force by six. When as much traction as he may deem safe has been attained, he fixes the pulley cord by twisting or knotting it to the loop of the traction belt, thus causing the spine to be immobile during application of the jacket.

As this sitting position and slight restraint are either not at all or very little fatiguing to the patient, the next procedure need not be hurried. Moreover, in order to insure greater hardness and durability to the jacket, some colloid may advantageously be mixed with the water in which the bandages are soaked. The best and most convenient material, in the author's opinion, is liquid glue. About a teaspoonful to the quart of water causes the plaster to set very firm and hard in from twenty minutes to half an hour, according to the warmth of the room. In winding on the bandages those parts of the traction and counter-traction belts which lie close and tight to the patient's body must be included and covered in the turns; those parts which project and stand away from the trunk are left out. By putting on the bandages, not straight, but somewhat obliquely, the chest and abdomen may be covered, with the exception of some little triangular spaces lying under the shelter of the projecting parts; these are afterwards dealt with.

When the plaster has become firm the traction should be slowly relaxed and the calico belts cut away about three inches from the trunk, and any little roughness in the angle where they begin to project removed. Then the triangular interspaces should be wetted and covered with plaster soaked in the gluey water. The calico lappers (the three inches not cut away) are then laid over the newly-applied plaster, and covered by rubbing into them the same material.

If the surgeon has to deal with a dorso-lumbar, or with simply a lumbar kyphosis, the lower belt becomes the traction band, passes to the front, and is attached to the pulleys; the upper belt is then the counter traction-band, passing across the front of the chest as high up as one wishes, and is secured behind. No lanyard is required.—*London Lancet.*

ON THE SPIDER-NÆVUS.—I wish to describe a form of nævus with which I have long been familiar, but which has, I think, not as yet received much special recognition. Its peculiarity consists in that it has a distinct centre, from which branches radiate in all directions. Its centre is very small, but is so definite, and apparently so active in filling its tributaries, tha

it might be compared to a minute heart. The size of the nævus is rarely greater than that of a fourpenny-piece or a sixpence. The condition of branching out from the centre suggests a resemblance to the small body and long limbs of some insects, and thus I have been in the habit of naming the whole the "spider-nævus."* If you put the finger on the middle of one of these nævi it may be completely emptied with but slight pressure, but the refilling when the finger is removed is instantaneous. The "spider-nævus," is never congenital, nor have I, so far as I can remember, ever seen it in very young children. After the age of five, however, it becomes common, and it is far more frequent in young persons than in adults. I have, however, recently destroyed a nævus of this kind, and of very well marked characters, on the temple of a gentleman of thirty-two, who held that it had been present only two years. Most of the cases which I have treated have been in young girls between the ages of seven and fifteen. I have seen far fewer in boys, but this may be because the disfigurement is less thought of in them. By far the most usual position of this nævus is the tip of the nose, but it may occur on any part of the face, and they are not unfrequently multiple. I have treated many of them, mostly, I think, on the children of my professional friends. It is sufficient to destroy the centre by a light touch of nitric acid. The limbs of "the spider" will usually afterwards shrivel; if they do not do so, they also may be lightly pencilled out with caustic. It is essential not to do too much at first, or a scar may be left more disfiguring than the original stain. The operator should bargain to be allowed to use the caustic several times if necessary rather than do too much at once. The "spider-nævus" always begins at its centre as a little red spot. It tends to grow, that is, to develop longer and longer limbs, for a year or two after its commencement, but not, I think, indefinitely.

It might be of interest to speculate upon its anatomical peculiarities. I have little doubt that, although not itself usually perceptible at

time of birth, it takes its origin in congenital peculiarity of structure. That its centre is in some slight degree pulsative seems highly probable. It is in the possession of this definite centre that it differs from all the other forms of nævus.—*Jonathan Hutchinson in Archives of Surgery.*

NOTES ON QUINSY.—Is there any connection between quinsy and gout, or between quinsy and rheumatism? Perhaps the latter is a more likely association. A lady who was liable to attacks of mixed rheumatism and gout, and who was also liable to quinsies, told me that she thought she usually had a quinsy just before her attack of rheumatism. My coachman, who has suffered from severe and definite attacks of gout in the great toe, is liable also to quinsies, but we have not observed any especial association between the two. The clinical history of quinsy is worthy of more attentive study than it has yet received. It is usually a very definite malady, differing entirely from all other forms of sore throat. It does not occur in conditions of debility, but to robust and healthy persons, and it is not, I think, associated specially with large tonsils. Only some persons are liable to quinsy, and those who are so have repeated attacks, each one just like the other, and usually with very long intervals between them. In the case of my coachman, above referred to, an interval of ten years of entire immunity had occurred. He has just passed through a very sick attack with an abscess in each tonsil, and such swelling as for a time almost blocked the throat. I believe that quinsy rarely begins simultaneously on the two sides, but that it rarely fails of being symmetrical in the end. One tonsil takes the start, and the other usually follows after a few days or a week. This was very definite in the case of my coachman, in whom I have just been studying the phenomena of the disease. He came to me first with a very hard swelling just above his left tonsil, and without the slightest affection of the other, and it was not until the first was on the point of breaking that the other tonsil followed in an exactly similar course. Acute and well-marked attacks of quinsy pass through definite stages, and subside completely after the abscess has given way or been opened leaving no chronic disease behind. It is very

* I am aware that in using this name I am only reviving one which was familiar to our ancestors. They had a "Nævus araneus." The name has, however, lapsed, and I am not acquainted with any definition which was ever applied to it. It may possibly have been used for exactly the same condition as that to which I now wish to apply it. If so, however, I have quite failed to find in the older surgical works any parallel description.

important to seize the right time for incisions in quinsy. They ought not to be made until the abscess is ripe, and they then give wonderful relief to the patient.—*Jonathan Hutchinson in Archives of Surgery.*

ON CAUSES OF DEATH IN MIDWIFERY.—The statistics of midwifery, and the causes of death after childbirth, are not without their interest for the operating surgeon. To a considerable extent the same kind of risks are encountered after delivery as after a large operation wound, and the same kind of precautions are needed.

My friend Dr. Aveling, one of the highest authorities on these matters, assures me that in spite of all modern improvements in practice the ratio of mortality after parturition in English practice has not been reduced lower than one in two hundred. The chief triumphs of recent days have occurred in the reduction of mortality in lying-in institutions. In private practice it is probable that for long the ratio has not been higher, and that no great change has resulted recently. It would appear, to judge from the statistics of individual practitioners, that it is very difficult even under the most favorable circumstances to beat the record.

I have before me a number of the *New Zealand Medical Journal* which contains the statistics of 2,590 cases occurring in the practice of one surgeon (Dr. Sealy). They give a mortality of 1 in 259, being just a little better than the average. It will be seen from the following list of causes of death that something of the nature of puerperal fever claimed about half.

- 1 from scarlet fever, 11 days after confinement.
- 1 from acute pericarditis, 2 days after delivery.
- 1 from uterine inflammation and fever, 18 days after.
- 1 from post-partum hemorrhage, half-hour after delivery.
- 1 from the effects of hemorrhage, 2 days after delivery.
- 2 from puerperal fever, each 9 days after delivery.
- 2 from typhoid fever, 12 and 10 days after respectively.
- 1 from bronchitis, 3 days after. (There was no particular temperature, and nothing septic in this case.)—*Jonathan Hutchinson in Archives of Surgery.*

HERPES AFTER-PAIN—ITS SEVERITY AND PROLONGED DURATION IN THE AGED.—All will agree, I think, in the opinion that the severity and duration of herpes after-pains are usually in ratio with the age of the patient. Young persons do not suffer from after-pain from shingles. In old people the pain may last for years. Of this the following case is, amongst many others, a good example.

Mrs. S—, an old lady of 70, suffered from herpes zoster a year ago. She avers that she is still never free night or day from a distressing aching pain in the parts which were affected (ear, neck, and shoulder). The pain does not now shoot and sting as it used to at first, but is rather an unbearable ache. Her nerve pains did not begin with any severity till the herpes spots were healing. This statement applies only to her skin, for the first symptoms which drew her attention to the eruption was a severe pain in the ear. She asserts that she has had earache ever since. I saw her in her first instance on June 16, 1889, at her own house, when she was just recovering from influenza. She was then in bed, and suffering so much from the herpes after-pain that she could not bear to be examined, and could scarcely speak to me. Since that she has visited me several times. She is a cheerful person, inclined to make the best of things, and she has now regained very fair health, but her complaints about the pain are incessant, and she will sit and weep during her visit to me. She says that it entirely prevents sleep at nights, and compares it to a gimlet boring into the ear. From the ear it passes down to the clavicle and tip of shoulder.

This is perhaps the most severe case that I have seen, but I have observed not a few which closely approach it. I have known several in which herpetic after-pains made the remainder of the patient's life a state of misery. They were all in old persons. Quinine and aconite are the most useful remedies, but I have had no triumphs.—*Jonathan Hutchinson in Archives of Surgery.*

THE HYGIENE OF THE TEETH.—The value of preventive measures against the attacks of disease cannot be too strongly insisted upon, and one class of case where these measures are,

to a great extent, within the control of the individual is in regard to the teeth. All caries of the teeth begins from the outside, no such thing as internal caries having ever been demonstrated; hence, if the surfaces could be kept absolutely clean, no decay could take place, however poor the texture of the teeth. This is, of course, impossible, but much towards such a desirable end can be attained by attention to hygienic rules. Parents often ask their dentists and medical attendants with reference to their babies: "When ought teeth to be cleaned?" The answer assuredly is: "As soon as there are teeth." A very small toothbrush charged with some precipitated chalk, flavored with an aromatic drug to make it pleasant, is perhaps the best means—not a towel, which only removes the secretion from the labial and lingual surfaces and not from between the teeth where decay is most rife. Yet how few children's teeth are so treated, and how rarely the habit of doing it for themselves when they are old enough is inculcated. But, if it be acquired, the very desirable result is likely to follow of an immunity from dental trouble—at all events to any large extent. Later on something more can be done by passing a piece of waxed dental floss silk, which can be obtained of most chemists, between the teeth every day, and the value of this can be easily demonstrated after thoroughly using the toothbrush by passing the silk between the teeth, when a certain amount of accumulated matter will be brought away. "Do toothpicks do harm or good?" is another question often asked. They may do harm if abused, undoubtedly, by causing irritation of the gum between two teeth and its subsequent absorption; and, if made of wood, splinters are liable to be left behind, which have, in many recorded instances, caused even the loss of a tooth; but used judiciously they are of great value in routing the attacking forces in caries—namely, accumulations of food and mucous secretions. It has been urged against them that they might dislodge a stopping. But if a stopping is so insecure it must be faulty, and the sooner it is replaced the better, for decay, due to the impossibility of keeping the surface clean, must be going on underneath it.—*Lancet*.

REMOVAL OF BOTH OVARIES IN THE THIRD MONTH OF GESTATION; DELIVERY AT TERM.—An interesting communication by M. Polaillon to the Académie de Médecine has reference to a woman who, in spite of a double ovariectomy performed in the third month of pregnancy, was, nevertheless, safely delivered at term. The history of the case is briefly as follows: First symptoms of the existence of an ovarian cyst appeared at the age of twenty-three, the patient being nulliparous. At the age of twenty-nine, menstruation having ceased for several months and symptoms suggestive of early pregnancy having appeared, severe pains in the abdomen suddenly developed. Examination revealed the presence of an enormous ovarian cyst, probably suppurating, the state of the patient being so serious that, despite the suspicion of pregnancy, it was decided to perform ovariectomy at once. At the operation M. Polaillon came upon a large cyst of the left ovary, adherent to the intestine and to the fallopian tube of the same side. The adhesions were ruptured, the proceeding giving rise to profuse hemorrhage. The left ovary having been removed, it was found that the right tube was the seat of the hemorrhage, and that the right ovary, which had attained the size of an apple, was likewise affected with cystic degeneration. The right organ was in its turn removed. Recovery proceeded satisfactorily and the woman was in due time delivered, the labor presenting no unusual features and the placenta being normal. The cicatricial line was not injuriously distended during the evolution of pregnancy. The lesson deduced from this case by M. Polaillon is that pregnancy may continue after the removal of the upper portions of the broad ligaments and despite the interference with the uterine and placental circulations entailed by the suppression of the superior uterine blood-vessels. He attributes the excessive hemorrhage which occurred during the operation to the extra vascularity of the parts due to the gravid condition of the uterus.—*Lancet*.

ALUMINIUM is to be used in the construction of artificial limbs, a use to which it seems to be particularly well adapted owing to its great strength and lightness.

THE
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS
OF THE MEDICAL SCIENCES.

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.

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TORONTO, SEPTEMBER 16, 1892.

DIET IN TYPHOID FEVER.

It is admitted now on all hands that medicinal treatment plays a secondary *role* in the management of enteric fever, and that the nursing, with its two main functions of feeding and bathing, plays the primary part in saving the patient. The feeding of a fever patient, of course, is now, since the days of the famous Irishman Graves, accepted as necessary but in no one of the duties of the physician is more careful discrimination necessary than in the proper selection of diet, both as to kind and as to quantity. Dujardin Beaumetz says: "The best treatment of typhoid fever is a good physician." There are certain general principles bearing on the case that seem to need only bare statement to secure general acceptance, and they apply mainly to the management of the acute stage of a continued fever, the stage of convalescence demanding management so different that in the case of typhoid some one has said that convalescence from typhoid fever is a second and different disease. These general principles may be applied with the acute stage of typhoid fever in mind. First, the great increase in the excretion of urea shows great wasting of the albuminous tissues, and either albuminous or albumen-saving material must be supplied. Secondly, the pyrexia seriously diminishes the capacity of the cells for assimilation of the albumen-bearing fluids in which they are bathed, even were these fluids present in the normal way, which they are not, owing to the constant disturbance of the digestive and absorptive powers of the intestinal tract. So that while the old practitioner who

starved his fever patient fell into Scylla's clutches and made no attempt to repair tissue waste, the modern one, if not careful, falls into Charybdis' and stuffs his patient, preferably with milk, overloading the digestive canal, whose functions are seriously impaired, and often greatly aggravating the restlessness, fever, diarrhoea, and vomiting of a patient whose condition may be in a single hour greatly improved by a large enema of gruel to remove the sour, offensive curds from the large intestine, or by the vomiting which relieves the overloaded stomach.

It may safely be said that one had better be forbidden the use of milk at all in typhoid than abuse it. And to lay down a routine rule, and say that all typhoid patients must take somehow at least two quarts of milk per diem is bad practice. Idiosyncrasy exists among the well, and is heightened, or perhaps first called into existence, in the sick, and rather than make a rule such as the above the physician should instruct the nurse to keep for his inspection, well covered and untreated with antiseptics, one dejection every day, that he may judge by inspection as to the digestion of the milk he is giving. Another common error is the idea that none but absolutely fluid food may be given. It is forgotten that "digestion is always a process of liquefaction," and that milk turns solid—at least the solid parts of it are aggregated into lumps by the action of the lab-ferment. Yet another point to be borne in mind is the increased need of water. In addition to milk and other fluid foods, water should be regularly given, either pure or mixed with the milk. Eighty ounces is the minimum amount of water necessary in one form or another per diem. And in the matter of both food and drink the patient's wish cannot be taken as a guide, since appetite fails early, and even thirst ceases to be felt when the need is greatest. Not more than two hours should elapse between times of feeding, and water is a food most nutritious to one dying for lack of fluid in the tissues. Making milk the main stay during the acute stage, and giving not more than one quart on an average daily of unskimmed milk, the deficit in albumin is to be made up by meat juices in various forms. If skimmed, more milk may be given. It may be in any case diluted with lime-water (a half ounce to four ounces of milk), with a

little barley-water, with any effervescing or alkaline table-water, and flavored, if the patient prefer it, with a little coffee-essence, vanilla, or similar agent. Of course the peptonizing powder is most valuable. As regards the meat juices, the first resort is the old, familiar beef-tea, chicken or mutton broth. These may, if prepared in the usual way, aggravate diarrhoea. They should be made by the cold process, with hydrochloric acid, that the albumin and gelatine may be really extracted, not coagulated *in situ* by the hot water in which the meat is usually placed. They should be *consommés* as thin as water, and flavored by hanging in the fluid a little bag with such vegetables as minced carrot, parsnip, celery, sage, savory, etc., adding both flavor and vegetable juices to the dish. This may be given twice daily. There are many preparations of meat peptones, the more recent seeming to be far preferable to many of the old ones. They are familiar by name, without invidious selection, and should be tried, both for their own value and as alternatives to the wearisome milk diet. Gelatine in any form is a valuable albumin-saving agent, and any of the wine-jellies may be sparingly and tentatively used. The best is milk-jelly, peptonized milk having added to it while warm the requisite amount of gelatin, and being flavored with rum, brandy, wine, etc. It may be given cold or warm, once daily or every other day. According to some, egg may be given if uncooked, or the raw taste may be removed by breaking the egg and rapidly stirring it in a thick delft cup which has been immersed in boiling water, the heat retained in the ware being enough to lightly cook the egg. Starch in any form is undesirable. Clinical experience shows its indigestibility, and theoretically the pancreatic secretion necessary for its digestion is probably as absolutely suppressed as the saliva undoubtedly is. So that gruel, custard, etc., are inadmissible though the slight amount of soluble starch in such a fluid as barley water does no harm.

During convalescence the difficulty is much increased, especially in private practice, by the clamorous appetite of the patient. The main thing to be borne in mind is the greatly enfeebled functions of the gastro-intestinal tract, and no fast rule can be given as to the number of days of normal temperature that may elapse

before adding to the diet list. The slight elevation of temperature that accompanies the digestive process is not to be taken as an incipient relapse, but must, of course, be kept within bounds and watched. Excellent authorities set the limit at two days of normal temperature, others as much as twelve. The state of the digestive functions, as determined by the progress and severity of the acute stage, should be the guide in making up the new diet list. The first addition might be one lightly boiled or poached egg, or a custard with little starch, or a little milk-toast. If no ill results, the same the next day, with, for dinner, some chicken or other broth, thickened with well-boiled rice, not with raw starch, and perhaps, in addition, some corn starch the next day. Milk must still be given in plenty. Soon a few oysters, with the hard adductor muscle removed, may be given, then small fragments of white meat, and gradually the meats and mashed potatoes reached, not earlier than the tenth day. Before this a moderate amount of good wine or bitter ale or porter may be advantageously given, as a stimulant and digestive tonic.

ADMINISTRATION OF CHLOROFORM IN THE PRESENCE OF A NAKED FLAME.

We often hear of the dangers of administering ether, in the presence of a naked flame, because it is so highly inflammable; and, in the same connection, it is generally supposed that the use of chloroform under such circumstances is quite safe. It has been pointed out, however, by Patterson and Martin, of England, and Zweifel on the Continent, that such ideas about chloroform are incorrect. Dr. Charles Martin recently read a paper on the subject before the Queen's College Medical Society (*Birmingham Medical Review*) in which he refers to the effects of chloroform when administered half an hour or more in the presence of an open flame such as gas jets. It produces in those present a dry, spasmodic cough, becoming to some quite serious, smarting of the eyes, pungent odor with stinging sensation in the nostrils, and a sense of oppression in the chest. He has noticed that in some cases the patient's condition be-

comes very serious, although he had never seen death ensue from such causes.

The proper cause of such symptoms was not for some time suspected, but was thought to be an impure carbolic acid spray, the use of impure chloroform, or fumes from a gas stove. Investigations in each case gave negative results. Finally, it was proved that the evil results were due to the decomposition of the chloroform in the presence of the naked flame and the formation of free hydrochloric acid. Dr. Martin thinks it is the presence of this hydrochloric acid that produces the irritating cough, the acrid odor, and the other unpleasant symptoms before described. The character of the flame does not appear to signify, as similar effects have been observed in the presence of gas and oil flames. The bad effects are not, as a rule, observed until the chloroform has been administered half an hour. The fact remains, however, that chloroform is safer under such circumstances than ether; but we should remember that when chloroform is administered for any length of time it is desirable to have as large a room as possible, and free ventilation.

CANADIAN MEDICAL ASSOCIATION.

We hope the next meeting of this association, to be held at Ottawa, September 21 to 23 inclusive, will be largely attended. The president, Dr. J. L. Bray, has shown a commendable zeal in his preparations for the event, and has been cordially assisted by the secretary and other officers. It is expected that a very important question will come up for discussion with reference to the place of meeting in the future. It is considered by many that the peripatetic system has seriously interfered with the success of the organization. There is, of course, nothing new in such consideration; but some are so strongly impressed with the gravity of the situation that they will propose to make a radical change, and, in the future, hold all the meetings in the same city. If such views prevail, it is likely that Ottawa, the capital of the Dominion, will be the place selected.

Mosso has determined as the results of a series of experiments that the brain is the warmest part of the body.

THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

The fifth annual meeting of this association will be held in St. Louis, Sept. 20, 21, and 22, under the presidency of Dr. A. Vander Veer, of Albany. It is unfortunate that it takes place at the same time as the meeting of the Canadian Association at Ottawa; and, as a consequence, the attendance of the Canadian members will not be large. We earnestly hope the mistake will not be repeated in future years, as our American brethren have been more than kind to those from Canada who have had the pleasure of attending any of the meetings of this young but vigorous society. Our able and genial friend, Dr. W. Warren Potter, of Buffalo, the indefatigable secretary, tells us this year's meeting will be a grand success.

Book Reviews.

Book on the Physician Himself, and Things that Concern His Reputation and Success. By D. W. Cathell, M.D. New tenth edition (author's last revision). Thoroughly revised, enlarged, and rewritten. In one handsome royal octavo volume. 348 pages. Bound in extra cloth. Price, postpaid, \$2 net. Philadelphia: The F. A. Davis Co., publishers, 1231 Filbert Street. Toronto: J. A. Carveth & Co.

This is not only a useful book, but also a very readable one. It gives the general physician good advice with reference to many points, but especially in regard to choosing a location and earning a reputation by honorable methods. The author considers that it is as necessary for the most skilful physician to possess a certain amount of professional tact and business capacity as it is for a ship to have a rudder. He tells us that, as physicians, we should make skill in preventing disease our central thought and our chief reliance, and, as men and brethren, should discharge each and every duty to our great Master's entire family, at all times and in all places, with fidelity and honor. The work has met with remarkable favor in the United States, and we see no reason why it should not prove quite as acceptable to Canadian physicians.

The Year-Book of Treatment for 1892. A critical review for practitioners of medicine and surgery. In one square 8vo. volume of 491 pages. Cloth, \$1.50. Philadelphia: Lea Brothers & Co., 1892. Toronto: J. A. Carveth & Co.

The "Year-Book of Treatment" is the joint product of twenty-one physicians and surgeons: Barclay J. Baron, M.B., Stanley Boyd, F.R.C.S., J. Mitchell Bruce, Alfred Cooper, F.R.C.S., George P. Field, M.R.C.S., Archibald E. Garrod, M.D., Handfield Jones, M.D., Reginald Harrison, F.R.C.S., Ernest Herman, M.B., Ernest Lane, F.R.C.S., Robert McGuire, M.D., Malcolm Morris, F.R.C.S.E., Edmund Ower, F.R.C.S., Sidney Phillips, M.D., Henry Power, F.R.C.S., C. H. Ralfe, M.D., E. S. Reynolds, M.D., James Ross, M.D., E. M. Skeritt, M.D., W. G. Smith, M.D., and W. J. Walsham, F.R.C.S., who give a classical epitome of the medical literature of the last year in a convenient and practical shape. The distinguished contributors have done their work well, and their publishers offer to the profession a very valuable little book.

Personal.

DRS. J. T. DUNCAN and J. C. PATTON, of Toronto, are now in England.

DR. J. E. GRAHAM has returned from his two months' holiday, most of which was spent in Switzerland, as our readers know from his letter published in last issue of THE PRACTITIONER.

DR. JAS. F. W. ROSS, of Toronto, has been elected one of the Honorary Presidents of the International Congress of Gynecology and Obstetrics, to be held in Brussels, September 13 to 18.

DR. BERGIN, of Cornwall (Surgeon-General), and Drs. Strange and Ryerson, of Toronto (Surgeons), have been elected Honorary Members of the Association of Military Surgeons of the National Guard of the United States.

PROF. OSLER, who was in Toronto a few days ago on his return from Europe, told us the meeting of the British Medical Association was an excellent one; but he was especially enthusiastic in his praise of the work done in the pathological section, under the presidency of Victor Horsley.

Therapeutic Notes.

MALARIA.—Dr. Samuel Wolfe (*Amer. Therapist*) speaks highly of resorcin, in the following combination, in the treatment of obstinate malarial toxæmic conditions:

℞ Resorcin ʒ iii
Tr. eucalypti fl ʒ i
Syr. limonis fl ʒ ii
Aquæ fl ʒ i

M. ft. solut.—Sig: Teaspoonful three times daily.

CYSTITIS.—M. de Laval (through *Boston Med. and Surg. Journal*) recommends the following formula:

℞ Ext. pichi fluid fl ʒ i
Potassii nitratis ʒ i
Syr. simplicis fl ʒ iii

M. ft. solut.—Sig: A teaspoonful every three hours.

EXFOLIATIVE MARGINATE GLOSSITIS.—Dr. Besnier (*le Bulletin Médical*) uses the following ointment:

℞ Cocaini hydrochlor ʒ 0.05
Bals. Peruv
Acid borici aa 1.0
Petrolati ʒ 30.0

M. ft. ungt.—Sig: Apply locally twice a day.

SEAT WORMS.—Minerbi (*Jour. de Med. de Paris*) reports good success in treating children for seat worms with naphtha used as a rectal injection. This is his formula:

℞ Naphthalini 1.0—1.5
Olei olivar. 40.0—60.0

M. ft. solut.—Sig: For a rectal injection.

ARTIFICIAL CARLSBAD SALF.—The following formula is given in *Archiv. de Pharm.*:

℞ Sodii sulphatis (cryst) 55.56
Potassii sulphatis 7.11
Sodii chloridi 10.00
Sodii bicarbonatis 33.33

Mix. 100.00

—*The Med. Fortnightly.*

THE THERAPEUTIC USES OF IRON.—The tonic and hæmatinic properties of iron were well known to the ancients. The old way of administering this metal was very curious. The metal being very much used in the pre-

paration of weapons of warfare, and Mars being the god of war, Mars became the patron of iron; and very frequently in old books we read of the "martial preparations," by which is meant preparations of iron, and the mode of administering them was to put a sword into a water-trough and allow it to lie there and rust, and to let the people drink of the water. Of course, it was a very mild chalybeate water that could be got in this way. But, still, very mild preparations of iron, if continued for a long period of time, will produce a very marked effect; and distinct results were obtained in ancient times from this very mild way of giving iron.—*Lancet*.

CHLOROSIS TREATED BY SULPHUR.—Dr. Schulz calls attention to the value of sulphur in certain cases of anæmia and to the excellent results obtained by the use of sulphur waters in malarial cachexia. He draws the following conclusions: (1) In cases of pure chlorosis in which iron proves inefficient, the general condition is decidedly improved by sulphur. (2) After the administration of sulphur has gone on for some time, treatment with iron can be commenced and continued with success. (3) In cases of chlorosis complicated with catarrhal and inflammatory conditions of the digestive tract, sulphur is contra-indicated.—*Berlin klin. Wochens.*

ARSENIC IN LEUKEMIA.—At a meeting of the Clinical Society of London, Drew (*Lancet*, 1892, No. 3588, p. 1244) presented a case of leukemia in a man in which after a course of three months of treatment with liquor arsenicalis in gradually increasing doses up to one hundred minims daily the greatly enlarged spleen became much reduced in size, while the proportion of colorless blood corpuscles diminished from 1:14 red to 1:400. The number of red corpuscles was increased, but the proportion of hemoglobin underwent but little change.—*Medical News*.

CREASOTE IN TUBERCULOSIS.—Penrose (*Medical Record*, April 9, 1892) reports upwards of one hundred cases of pulmonary tuberculosis which have been treated with creasote. All of the cases improved, and though none were cured, owing to the advanced stage

of the disease, many of the patients are now at work who would, in all probability, have died but for the use of the drug. He thinks it most important that pure beechwood creasote should be used, and the dose gradually increased.

Miscellaneous.

RESOLUTION OF THE MEDICAL PRACTITIONERS OF OTTAWA.—At a meeting held this 1st day of August, 1892, of the Ottawa members of the Bathurst and Rideau Medical Association, which includes all the registered medical practitioners resident in the city of Ottawa, the following resolution was carried unanimously:

Resolved: That this meeting having been officially informed of the action of the Dominion Government whereby by Order in Council "Every qualified medical practitioner whose name is registered in the Medical Register of the province in which he resides is appointed an authorized medical practitioner for the purpose of issuing medical certificates as required by the Civil Service Act," they desire to express their full appreciation of the courtesy thus extended to the members of the medical profession throughout Canada; and they believe also that this course is in the interest of the members of the Civil Service, equitable towards the members of the medical profession, and equally protective to the interests of the Government, as compared with the former regulation of having only one authorized physician in each locality.

Resolved: That this meeting is of the opinion that it would be well for the Government to adopt and have printed a form of blank medical certificate to be filled out by physicians giving such to civil servants who are ill and under their care.

Resolved: That whilst the members of this Association desire to express the opinion that there is no body of men who would more readily condemn a physician for wilfully issuing an unwarranted and unworthy medical certificate than the members of the medical profession, and whilst they declare that such a physician would be deserving of the severest censure and his name should be erased by the Government from the list of authorized medical practitioners, yet inasmuch as there are cases where the trained medical mind is enabled to discover slight symptoms of disease, indicating serious possibilities in the near future, where divulgence might thwart the chance of cure, together with the fact that the lines of professional secrecy are inelastic and demand invariably the most honorable observance, it would be but justice that before any physician's name is removed by Order in Council from the list of authorized medical practitioners under the Act for reported irregularity

he should have the right extended to him of explanation and of defending his action.

Resolved: That a copy of this resolution be sent to the Dominion Government, through the Honorable the Premier, Sir John Caldwell Abbott, and that a copy be also sent to all the medical journals in Canada.

A. F. ROGERS, M.D., *President.*

H. B. SMALL, M.D., *Secretary.*

THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.—A very full program is announced for the coming meeting of the American Electro-Therapeutic Association, which is to be held in New York, at the Academy of Medicine, 17 West 43rd Street, October 4th, 5th, and 6th. There will be two interesting discussions, one upon "The Relative Feticidal Value of the Different Currents and their Application to Ectopic Gestation," to be discussed by many prominent gynecologists and electricians, and another upon "Cataphoresis and its Practical Application as a Therapeutic Measure." Papers are announced by Drs. Geo. J. Engleman, Wellington Adams, and Geo. F. Hulbert, of St. Louis; Wm. F. Hutchinson, of Providence, R.I.; Franklin H. Martin, of Chicago, Ill.; A. Laphorn Smith, of Montreal, Canada; R. J. Nunn, of Savannah, Ga.; Thomas W. Poole, of Lindsay, Ontario; C. Eugene Riggs, of St. Paul; W. J. Herdman, of Ann Arbor, Mich.; D. S. Campbell, of Detroit, Mich.; G. Betton Massey, of Philadelphia; Henry D. Fry, of Washington, D.C.; H. E. Hayd, of Buffalo, N.Y.; J. H. Kellogg, of Battle Creek, Mich.; C. G. Cannaday, of Roanoke, Va.; Ernest Wende, of Buffalo, N.Y.; and Wm. J. Morton, Augustin H. Goelet, A. D. Rockwell, Landon Carter Gray, Robert Newman, Ephraim Cutter, Frederick Peterson, G. M. Hammond, F. Van Raitz, of New York, and many others. Dr. J. Mount Bleyer will give an instructive lecture with demonstrations, entitled, "The Phonograph and Microphonograph, the Principles Underlying Them, and their Uses in the Sciences." In connection with the meeting there will be an exhibition of modern medical electrical apparatus, all the prominent manufacturers being represented.

LARGE FEES.—A Chicago physician has received \$2,000 for his services in a case of intu-

bation for diphtheritic laryngitis. The parties disputed the bill for six months, and at last put it in arbitration. The full charge was allowed and promptly paid. A New York physician was not so fortunate. His bill was \$2,500 for ten days' attendance on a case of typhoid fever in a southern town. The matter was sent to a jury, who awarded the doctor \$1,500. These cases have both been somewhat *causes célèbres*, and have led to many satirical remarks about doctors' fees. There may be extortionate charges occasionally; but, take it as a whole, the physician is poorly paid for the work he does. He never accumulates riches, and is generally fortunate if he saves enough for his old age. Medical services are worth more than in former years, and should be better paid.—*Medical Record.*

A STATUE TO RICORD.—The world owes a debt of gratitude to the man who, by his labors in the investigation of syphilitic diseases, confirmed (in 1838) Benjamin Bell's views (dating from 1793) as to the non-identity of gonorrhœa and syphilis. It was not to be expected that Ricord's name and fame would be allowed to remain unrecognized, and the Paris municipal council have authorized the placing of his statue on a spot in the Boulevard de Port Royal, exactly fronting the Hôpital du Midi, the scene of his labors and teaching for thirty years.—*London Lancet.*

FEMALE PHYSICIANS AND THE BRITISH MEDICAL ASSOCIATION.—A resolution was passed at the recent meeting of the British Medical Association at Nottingham expunging a section of the articles of association that provided that no female should be eligible for election as a member of that association. The question was first agitated in 1878, when it was decided, by a large majority, to make no change.

THE following are the delegates to the Dominion Medical Association, which convenes at Ottawa, September 20th, from the Ontario Medical Association: Drs. R. W. Hillary, president; J. E. Graham, Chas. O'Reilly, and D. J. Gibb Wishart.

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