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CONTENTS.

Original Communications.

INTERSTITIAL OR TUBO-UTERINE GESTATION, WITH NOTES ON SIMILAR CASES IN THE MUSEUMS OF LONDON HOSPITALS.

(Communicated to the Canada MEDICAL RECORD).

BY ALBAN DORAN.

This preparation consists of a uterus and its appendages, showing a cavity on the right side of the fundus, which has ruptured and discharged a fœtus and its membranes into the abdominal cavity.

A brief history of the case was published in the "*British Medical Journal*," October 14th, 1882, by Mr. Carr Holstok Roberts, of Kilburn, who has presented the uterus to the museum of the Royal College of Surgeons. In that collection, which possesses a fine series of preparations illustrating tubal gestation, this specimen is, at present, unique.

The patient was a tall and stout married woman, aged 32. Her two only children had been born at the full period, the youngest was fourteen months old, and had been weaned about two months; she had neither menstruated during lactation, nor seen a period since the weaning of her last child. At 10.30 p.m. on October 1st, 1882, she was seized with severe abdominal pains when in bed. Her husband gave her brandy, but without any good effect; he then sent for Mr. Roberts, who found that her abdomen was neither swollen nor tender, although she complained of severe pain. The patient was also suffering from sickness and slight diarrhœa, caused, according to her belief, by some strong pills. The vomit consisted of half-digested food, and the motions were such as would be produced by a purgative. The patient's skin was cool and moist, her pulse good, and her respiration and temperature both normal. Sedatives, hot fomentations and linseed poultices to the abdomen were ordered, but at 8 a.m. on October 2nd, Mr. Roberts, when sent for, found her in a state of collapse; she remained perfectly conscious until 10.30 a.m., when she expired.

When the patient's body was examined after death no external marks of violence were found, the abdominal cavity was filled with nearly six pounds of clot, and five pints of a bloody fluid. Floating in this fluid was a fœtus, at about the second month of development, enveloped in its membranes. It measured one inch and a half in length. At the upper part of the uterus a rupture was detected, large enough to admit three fingers. The thoracic, and abdominal viscera were normal, excepting the heart, which was very flabby, and its chambers perfectly empty.

I have since dissected and prepared the uterus. The greater part of its posterior wall has been removed to show more perfectly the relations of the cyst. The uterus is five inches long, from the

fundus to the os externum, and appears very unsymmetrical, on account of the bulging of the cyst at its right upper corner. The walls are, posteriorly, from a fifth to a quarter of an inch thick, and the cavity is lined with a well-formed decidua.

The right side of the fundus is dilated, and rent asunder by a long ragged aperture, measuring two and a half inches when unstretched. The cavity thus exposed measures one inch and a half vertically, supposing the edges of the rent to be closed, and one inch antero-posteriorly. The walls are very thin along the line of laceration.

Anteriorly, the right round ligament springs from the outer aspect of the exposed cystic cavity which bulges freely, at its lower aspect, into the upper part of the interior of the uterus; at this part its walls are much thicker than above. The inner wall of the cyst, as we may term it, is very rough, resembling, to a certain extent, an auricular appendix. From some of its numerous pits or depressions hang broken-off tags of chorion, but there is not a trace of a distinct decidua.

The right Fallopian tube passes into the outer and anterior aspect of the walls of the cyst, expanding slightly into a funnel-shaped orifice, which opens into the cavity of the cyst, close to the rent in its walls. A stout bristle, introduced into the tube from without, passes readily into the cavity through the funnel-shaped orifice, which is lined with very smooth mucous membrane. On the outer surface of the portion of the cyst that projects into the uterine cavity is another funnel-shaped aperture with a smooth lining. A bristle has been passed from without, through this opening, into the cavity of the cyst without meeting with the slightest obstruction.* This sufficiently proves the tubal origin of the cyst, there being no evidence of rupture of the wall of the uterus out of the line of the tube, as it runs through uterine tissue into the uterine cavity. Still less is there any ground for believing in a partially bicornute condition of the uterus.

The right ovary measures $1\frac{1}{10}$th inch in length, it is flattened and four follicles are dilated to a maximum of $\frac{1}{12}$th inch diameter. It contains a true corpus luteum of triangular form, $\frac{2}{5}$ths of an inch in its widest measurement, lying far from the free border of the ovary towards the ilium, having ruptured on one side of the ovary. The left ovary is half an inch in its longest diameter, and contains no palpably dilated follicles, the left tube presents no abnormality.

The two sketches which accompany this paper are taken from drawings made by Mr. Sherwin. The first represents the relations of the cyst to the uterine cavity, the second shows the interior of the cyst and the rent in its walls. Before entering into general considerations, it will be advisable to compare this specimen with others that, existing in the metropolis, may be conveniently compared with Mr. Roberts' case by members of our Society.

I could find no specimens of interstitial or tubo-uterine pregnancy in the museums of St. Bartholomew's, St. George's, St. Mary's, Westminster, St. Thomas's, Middlesex, and Charing-Cross Hospitals, nor in the museum of King's College, or in the collection preserved at the Hospital for Women, Soho Square.

In the museums of three medical schools, only, do such specimens exist, and I have examined them all, in order to compare them with Mr. Roberts' case. The following brief notes may prove acceptable for convenience of reference.

Guy's Hospital, No. 2517^{65}.—"The ovum was imbedded in the left horn of the uterus. The cavity is about the size of a horse-chestnut and is quite closed. The uterus is much increased in size, the cavity is filled by an exuberant growth of deciduous membrane closing the Fallopian tubes." Death from rupture occurred at about the second month, the case is recorded in "Guy's Hospital Reports," series ii. vol. iii., p. 272. The cyst is of precisely the same character as in Mr. Roberts' case, but of not half the capacity. The Fallopian tube runs into its outer wall. No communication of the cavity with the interior of the uterus is indicated.

No. 2517^{90}. "At the fundus" of the uterus "is a large cyst, formed within its walls; in this the fœtus," which is over four inches in length, "was contained, at its upper part a rent was seen. The cavity is about three inches in diameter, and is situated in the uterine walls adjoining the left Fallopian tube." The uterus is lined with a decidua, as in the last specimen; a corpus luteum exists in the corresponding ovary; the case is recorded in "Guy's Hospital Reports," series iii., vol. vi. p. 275. This is a beautiful specimen, the cyst is clearly continuous with the tube, and bulges into the uterine cavity as in Mr. Roberts' case,

* This patulous condition of what represents the uterine orifice of the tube has been already observed in similar cases by Peppell, as quoted by Parry.

which, in degree of development, as indicated by the clinical history and the size of the cyst, lies midway between the two specimens in Guy's Hospital.

London Hospital.—The two examples in the museum of that institution are immortalised in the late Dr. Ramsbotham's 'Principles and Practice of Obstetric Medicine and Surgery.' Unfortunately, neither specimens show the relations of the tubes, uterus and cyst intelligible. In E*h* 24 "the bones of a fœtus, probably near full time, are seen lodged in a sac behind the uterus; they are as clean as if macerated." "A portion of one of the long bones," says Dr. Ramsbotham, "protruded from the cyst into the cavity of the colon." The further account of the dissection, in that author's work, not quoted in the catalogue, leaves little doubt that the cyst which "occupied the right side of the uterine walls" is truly tubo-uterine. Had the cyst been in the free part of the tube, no matting together of the parts, by adhesions could have forced it into the uterine walls, but it is unfortunate that the relations of the right Fallopian tube cannot be seen. The specimen might, however, be an example of a hernial pouch in the uterus, such as Dr. Roper has described; to this question I shall presently return.

E*h* 105 is "a shrivelled fœtus of about four months which has escaped through a laceration in the uterine wall, in a case of parietal gestation." The cyst and uterus are included in the specimen. Dr. Ramsbotham most truly observes that the preparation does not display the peculiarities of the case well "having been taken from the body hurriedly and at great disadvantage." By the courtesy of Dr. F. C. Turner I have been enabled to examine this specimen very closely. The lower part of the cervix with the os externum has been cut away, the uterus has been laid open from the fundus to close above the cervix. The cyst has been completely severed from the uterus and sewn on to it by threads passed through their serous lining only. It has no aperture excepting the rent through which the fœtus escaped, but, on close scrutiny, the edges of the lower part of this aperture are found to be uterine tissue, cut artificially in dissection. Moreover, the tube and the ovarian ligament proceed from the outer aspect of the cyst, precisely as from a uterus; the ligament of the ovary never springs from a true tubal cyst in this manner. The whole aspect of the cyst, from outside, is like the uterus from which it has been severed, and its walls are of pure uterine tissue. Dr. Ramsbotham's description of the dissection leaves little doubt of the true nature of the specimen; the cyst was "formed within the walls of the uterus," and "one tube was attached to the cyst." The same author figures Breschet's case which bears all the appearance of being tubo-uterine.

The museum of *University College* possesses one specimen (35-43) labelled "A case of extra-uterine fœtation in the substance of the uterus,* close to the end of the Fallopian tube. Rupture of the ovum at seventh week, hæmorrhage and death in twenty-four hours." The manuscript catalogue describes the specimen as having been taken from the body of a young woman, and the rupture of the cyst was clearly caused by violent exercise. This specimen is well prepared, the cyst is not half an inch in diameter, being smaller than in the specimen 2517^{65} at Guy's Hospital. There can be no doubt that the cyst is here a dilatation of the part of the tube that passes through the uterine walls, a bristle has been introduced through the tube into the uterus, and it traverses the cyst, concealed by the chorion which lines the inner aspect of that abnormal cavity. The uterus possesses a decidua.

Thus, including the preparation from Mr. Roberts' case there appear to be six examples of so-called interstitial fœtation mounted as pathological specimens in London museums. It is most significant that, in all the four where the condition of the affected parts has been intelligibly displayed, the tubal origin of the "interstitial cyst" is self evident.

These notes are intended to be strictly pathological, still they suggest certain obstetrical considerations. "Interstitial" or tubo-uterine pregnancy is a rare accident, as our London museums prove, for practitioners are never backward in presenting to such collections specimens of extra-uterine gestation, and the numerical richness of a series is facilitated by the fact that sudden death is so frequent an ending of this abnormality of gestation that a necropsy is generally allowed, or even enforced by a coroner. Hence we see a goodly

* Dr. Barnes would be thoroughly justified in the use of his term "ectopic gestation" in such a case as this, where the older term reads as an absurdity see 'Trans. Obst Soc.,' vol. xxiii., p. 94), but space prevents me from entering into questions of synonyms.

array of the more frequent tubal form in almost every museum; since 1877 I have dissected and mounted no less than four, for the museum of the Royal College of Surgeons alone. The records of our Society's 'Transactions' teem with cases of tubal gestation. Yet notwithstanding the publicity thus given to extra-uterine fœtation, only six specimens of the tubo-uterine form can be found in the metropolis. In Parry's standard work, 31 cases of this variety are included in a table of 500 cases of extra-uterine pregnancy; but in that table 230 cases are set down as "doubtful." This ambiguous series, however, must have been mostly made up of cases that were chiefly doubtful as to their originally tubal or "abdominal" character; cases of hopeless matting together of pelvic structures so common in all such disorders when of long standing; but interstitial fœtation is less likely to be overlooked and classified among these 230 doubtful cases.

In fact it seldom reaches the stage at which it becomes "doubtful" to a dissector. Interstitial pregnancy generally ends in a "fœtal cataclysm," as Dr. Barnes would say, at the second or third month, as in Mr. Roberts' case; hence there is no time for pelvic peritonitis, burying the ovaries in adhesions and contorting the tubes in every possible direction.

This tendency to early rupture of the cyst involves, of necessity, great difficulties in diagnosis, which is practically impossible during the first few weeks.* In these days of abdominal surgery a rescue of a case like that of Mr. Roberts, by a very experienced operator may yet be recorded; but the very circumstances under which this accident must occur will seldom bring the patient within timely reach of a surgeon who can manage complicated cases of ovarian and uterine tumours. A purely tubal cyst, even at this early stage, certainly bleeds less rapidly, moreover diagnosis is not so difficult; on the other hand the soft swelling on the right of the uterus in Mr. Roberts' case could hardly have been detected on palpation, although abdominal section would have revealed its true character. Then, amputation of the uterus above the cervix would have been the sole practicable course.

The tendency to early rupture is clearly due to the thinness of the cyst towards its upper or peritoneal aspect. The lower portion of its walls tend rather to grow thicker, and, supposing that the upper part does not rupture, pregnancy may continue till term. Rokitansky has described such a case, quoted in several works by contemporary writers. I can well understand how the fœtus might be born into the uterine cavity, after expulsion from the sac, and then directly, or after an interval, delivered from the uterus "into this breathing world" in the usual manner. Dr. Mundé describes a case* where he fully believes that such a phenomenon occurred; the patient recovered, so that the precise condition of the parts could never be ascertained.

The cases of suspected hernial embryo-bearing pouches of the uterus, well known to Fellows of the Society, may, in many instances, have been really tubo-uterine cysts, and there is every reason to believe that the former uterine orifice of the tube, in the part of the cyst that projects into the uterine cavity, might become dilated, from various causes, so as to admit a sound or even the fore-finger. This orifice might dilate, in the delivery of the fœtus into the uterus, as the os externum dilates in natural labor, but it is more probable that it would be rapidly rent asunder. In the discussion on Dr. Barnes' paper on the so-called "Missed Labour," Mr. Spencer Wells and Dr. Gervis suggested the possibility of some missed labor cases being instances of tubo-uterine pregnancy.† But the cases quoted in support of this theory were theoretical, in so far as they all recovered, as did Dr. Mundé's patient; besides, the tubo-uterine nature of the pregnancy was based on the fact that the sound had been previously passed into an (apparently) empty uterus, without producing abortion; but this accident does not always follow the introduction of a sound into a normally gravid uterus. On the other hand, Dr. Roper's cases, mentioned by him in the same discussion, appear to have been verified by dissection; that obstetrician believes in hernial pouching of the gravid uterus through rupture of a part of its inner

* Dr. Gibbes, of South Carolina, distinguished a tumour in a case of tubo-uterine pregnancy, which he took for a fibro-myoma, and De la Faille correctly diagnosed a case from the intense pain caused by pressure on the uterus.—(See Parry, 'Extra-Uterine Pregnancy.')

* 'American Journ. Obstet.,' 1879, p. 330. The same remark applies to Dr. Lenox Hodge's case, just published in Parry's work.

† 'Trans. Osbt. Soc. vol. xxiii., p. 100.

wall.† Should his cases have really been correctly interpreted in this fashion, I am inclined to rank among them the specimen Eh 24, in the London Hospital Museum. Still, I suspcet that some such cases were tubo-uterine cysts. When developed to a very great size their relation to the Fallopian tube might become confused and constitute a source of fallacy. As to pregnancy in one horn of a double uterus, it has so clearly nothing to do with the specimen I exhibit this evening, that it is unnecessary for me to discuss that subject.

The cause of the arrest of the ovum in the uterine part of the Fallopian tube is not, in Mr. Roberts' case, self-evident. The cavity bearing the fœtus appears to be a pure dilatation of the tube; as in most similar cases, there is no evidence that the muscular structure of the uterus itself has been ruptured; hence the unsatisfactory character of the term "interstitial." Such a rupture would if it could be proved by dissection, have occurred from some uncertain cause, before the arrest of the ovum, for a very young ovum could hardly burst the tube, whilst, were the tube ruptured in its uterine part already, we can understand how an ovum might be forced into the uterine tissue, in stead of into the uterine cavity. The uterine orifice of the tube, that is to say, in this case, the aperture in the lower part of the cyst, is quite patulous, and there are no traces of any polypi-obstructing it, as in cases related by Beck, Breslau, and Leopold.* Yet, although the uterine orifice of the tube was unobstructed at the date of the patient's death, it might very possibly have been obstructed by catarrhal swelling of the mucous membrane some eight weeks earlier, and this would have been sufficient to arrest the ovum. On the other hand, a dilatation or tortuous condition of the uterine part of the tube might have existed before conception, and if so, it is easy to understand how the ovum was arrested in it; Leopold discovered an abnormal and crooked condition of this part of a left tube, in a case where the corresponding portion of the right tube held a fœtus. I believe that the truth lies between these two explanations, but that the second is more probable than the first.

† Since this paper was read, a "Case of Intra-mural Pregnancy Resulting in Missed Labor" has been contributed to the "British Medical Journal" (November 18th, 1882), by Mr. C. E. Steel, of Liverpool. In this case "the Fallopian tubes were normal, and opened into the uterus separately from the sac." Thus there can be little doubt of the nature of the sac, which could not possibly have been tubo-uterine.

* "Zur Lehre von der Graviditas Interstitialis," 'Archiv. fur Gynæokogle,' vol. xiii. heft 3.

Society Proceedings.

Stated Meeting, April 27th, 1883.

THE PRESIDENT, R. A. KENNEDY, M.D., IN THE CHAIR.

Case for Localization.—Dr. Osler presented a patient with the following history: Francis ———, aged 41, married fifteen years. Not known to have had syphilis, though he lost one child shortly after birth with a skin eruption. Has enjoyed good health, with exception of present trouble. For six years he has had epileptic fits; at first at rare intervals—one in three months—but now one every fortnight. Liable to have them at any time if much excited. They are, his wife says, confined to the right side, towards which, also, he tends to fall. Not known whether they begin in hand or foot, as he has not had a fit since under observation; always loses consciousness. Nearly two years ago he began to have trouble in the right leg, jerkings and stiffness, which have steadily increased. The right arm was also weak, and for the past five months the speech has been affected. His memory is not so good as it was, and at times he is irascible. He has had two injuries to the head; the first when a lad of seven or eight, which has left a long scar on the right side, high on the parietal bone. There is no adhesion of the skin and no depression. The other was received by the fall of a scantling, seventeen years ago, and is a flat scar a little behind bregma on the left parietal bone. It is not depressed, and the skin not adherent. At present nutrition of muscles good; he walks with difficulty, owing to stiffness of right leg, in which the spastic gait is well marked. Reflexes greatly increased in the leg. Knee-tap somewhat exaggerated also in the left. Right arm does not appear much affected, but he says it feels weak. Grip is good; dynamometer shows it to be a little weaker than the left. Slight paralysis of lower facial muscles; tongue deviates strongly to the right, uvula drawn towards the left. Speaks with hesitancy, and is often at a loss for a word. No impairment of sensation. No optic neuritis or retinitis. The patient's head was shaved and Broca's lines drawn in order to define the exact position of the old injury on the left side. It is just behind the bregma, and would correspond on the cortex of the brain to hinder part of the superior frontal convolution. The symptoms point to a lesion of the

motor area on the left hemisphere, situated about the upper end of the fissure of Rolando, along the ascending frontal, and extending to the inferior frontal sinus. The character of the convulsive seizures, unilateral, the monocrural rigidity, the dissociation of the paresis, leg and face and gradual extension, point to a cortical lesion; but whether connected in any way with the old injury is somewhat doubtful. The question of trephining in such a case naturally suggests itself, and may come after further study of the case.

Dr. Roddick stated that he had known the patient for some time and he had suggested the advisability of trephining at the site of the old injury, but had been overruled by his colleagues.

Chyluria, not Parastic; Autopsy.—Dr. McConnell read the report of the case. A woman, aged 33, native of the Province; married ten years, two children. Eleven years ago she noticed that the urine was milky Had been healthy up to that time, but ever since had not been so strong. The white appearance of the urine has persisted, with occasional periods of intermission, two of which were while she was pregnant. Came under observation on October 27th. Was pale, anæmic, moderately emaciated. Appetite good, is constantly hungry, and eats five or six meals a day; sleeps well; bowels very constipated. Has to make water very frequently, nearly every half hour, and is of the color of milk. Sometimes very painful to pass from the presence of thick, clotted portions. A sample passed was quite fluid when fresh, but in a few minutes a large part of it curdled. Examination of abdominal organs negative. In chest, râles at apices of lungs. On three occasions the blood was carefully examined by Dr. Osler and myself, a number of slides at a time, and the blood taken after midnight, but no filarian embryos were ever discovered. The quantity of urine passed was estimated for several days, and ranged from six to eight quarts; often the clots were blood-stained. Microscopically, it presented fatty molecules, like the molecular base of the chyle a few blood-cells and leucocytes. Repeated examinations failed to detect any parasites. The condition of the patient grew gradually worse through the winter; the cough became more distressing, and the digestion much impaired. Death took place on the 5th of March. For three days before dissolution the urine was bloody and not so abundant. The *Post-mortem* was held on the 18 inst., the body, which had been in vault of the cemetery, was in a good state of preservation. A careful dissection was first made of the thoracic duct and receptaculum, but, as the specimen shows, it appeared perfectly normal, perhaps a little small, but pervious throughout, and contained a bloody lymph. No dilated lymph vessels about the kidneys, or any special connection between renal and abdominal lymphatics. The mesenteric and retro-peritoneal glands were a little enlarged and firm, and, on section, presented opaque areas of fatty degeneration. No caseous or calcareous glands. Lacteals not distended. Kidneys were of average size, capsules detached easily, substance a little blood-stained, but looking very natural. Ureters normal. Bladder contained six or eight ounces of bloody flood, which had clotted. Mucosa normal. Inguinal and pelvic lymph glands not enlarged. Turbercular cavities at apices of lungs and a few ulcers in the ilium. The lymph glands, retro-peritoneal tissues, mesentery, and kidneys were subjected to prolonged microscopical examination without producing a trace of anything parasitic, or, indeed, of anything which threw any light on the nature of the affection.

Dr. Roddick asked if it were not possible that in the course of the disease the filaria might disappear?

Dr. Osler thought it not probable, without leaving some trace of the presence of the adult worms which live in and about the lymph glands in pelvic and peritoneal tissues. The value of this case was considerable, as it showed that we should not regard, as some recent writers do, chyluria and the filarian disease as identical.

Inflamed Umbilical Hernia.—Dr. F. W. Campbell read the notes of the case: Stout woman aged 64, had had irreducible umbilical hernia for fifteen years. Had been seen four years ago, with a painful attack in the hernia which subsided in a few days. On the morning of April 9th was sent for, and found her suffering great pain in the sac. The pad had got off, and without waiting to replace it, she had jumped out of bed, and was at once seized with severe pain. The hernia has been getting a little larger of late, and the pad was too small. It was at once reduced to the usual size without difficulty, but the pain continued. Liq. opii. sed. was given (hypodermic). An enema brought away many scybala. In the afternoon, she was not so well, and vomiting set in. On the 10th she was easier, and on the 11th pain was well kept down, but the vomiting was excessive. An

injection brought away a large fecal stool. Had a restless night on the 12th; pain has returned, but not so severe.

Was seen by Drs. Howard and Fenwick, but it was decided that the symptoms scarcely justified an operation. Through the 13th and 14th she kept about the same; the vomiting not so frequent, and on the evening of the 14th she seemed very much better. Early in the morning of the 15th she got much worse, became cold, sank rapidly and died in a few hours. The autopsy showed a thin-walled unbilical sac, not inflamed. In it were two coils of intestine; one, about thirteen inches in length, was dark-colored, deeply congested, and inflamed; the other, nine or ten inches in length, was natural looking, though a little swollen. Two fingers could be passed into the ring; there was no strangulation. There was no adhesion of the bowel to the sac. The inflamed portion of the bowel presented two flat bands of slightly thickened peritoneal tissue, where it has been probably for years in contact with the ring. The inflammation had extended along the adjacent coils in the abdomen for a few inches. When slit open, mucosa intensely inflamed, of a deep, lividred color, and covered with closely adherent flakes of croupous exudation. Heart fatty. No other changes of note.

A difference of opinion had existed regarding the existence of strangulation in this case, and the propriety of operating. From the *post-mortem* appearance, it did not seem probable that nipping of the bowel had occurred, as the ring was large and a healthy coil was in the sac. It may have been simply the result of a primary inflammation of the hernial coil, which had evidently been in the sac for years, as it was dark with pigment. One of the most inexplicable features of the case was the sudden heart failure; but she had been taking very little nourishment, and the vomiting had reduced her strength very much.

Cancer of the Stomach.—Dr. Wood presented the specimen and narrated the case. A woman, aged 55, had suffered for a year or more with dyspeptic symptoms, and two months ago had vomited a small amount of blood; had lost flesh, but was not cachectic. No tumor of abdomen could be made out, but cancer of the stomach was suspected. The details of the last week of her illness are as follows: On April 14th, 15th, and 16th she had a good deal of nausea and vomiting; on the 17th she went to bed, and I saw her for the first time in several weeks. There was vomiting and considerable epigastric pain; pulse about 90. On the 18th she was easier; 19th much worse; fainted in the night; pulse weak, 115; face pale, feet cold, vomiting frequent. In the evening the temperature was 101°; pulse 120; the pain in abdomen was more diffuse, and there was considerable distension. On the 20th, condition did not improve, though, under opium, the distress was not so great. On the 21st prostration more marked, and the next day the vomiting was distinctly fecal and frequent. Death on the 23rd.

At the autopsy, the small intestine from an inch or two below the duodenum to within two inches of the valve, was dark in color, distended, and covered in places with a thin sheeting of lymph. Several spots in the ileum looked almost gangrenous, and here and there extravasations had taken place. The coats were infiltrated, the mucosa soft, and there were three spots (ulcers) from which the membrane had disappeared.

The stomach, as shown by the specimen, presented a large open cancer, involving the cardiac end, and completely encircling the organ. Several loose sloughs adhered to the surface, but over a great part of its extent the muscle fibres were bare. There was thickening of the peritoneal surface and a few secondary nodules. In looking for the cause of the condition of the bowel the vessels were carefully examined, and the superior mesenteric artery found to be plugged.

Sarcoma of Kidney in child 5 years of age.—Dr. Alloway briefly related the following history of this case:—The disease, when first noticed, appeared as a tumor, extending from below the ribs to within an inch of the crest of ilium, on the right side. The growth gradually increased during the next three months, until, at death, it filled the whole abdominal cavity. The tumor weighed nine pounds, and was, on microscopical examination, found to be a round-celled sarcoma.

Dr. Osler also exhibited *Scirrhous disease of pancreas and colloid lung*, taken from the same patient, and the *kidneys* from a man found in a comatose condition outside the city. He was brought first to a police station, and from there sent to hospital. He never became conscious, but died a few hours after entering hospital. Albuminuria was suspected; the catheter was used, and urine loaded with albumen withdrawn. The kidneys were about normal size, and but slightly congested.

Dr. Shepherd then exhibited specimens as follows :—

1. *Abnormalities of Aortic Arch.*—(*a*) A case of large middle thyroid artery. It passed up the middle of the neck lying on the trachea, and divided about half an inch below the cricoid cartilage into two branches, which went to right and left side of the trachea. (*b*) Two examples of the left carotid arising from innominate artery instead of from the arch. This was mentioned as being the normal arrangement in many animals, as the dog, rabbit, &c. (*c*) One example of a left vertebral arising from the arch of aorta instead of from the subclavian. It was of large size. The right vertebral was very small, not being larger than a crow quill. The branches from the right subclavian in this case came off separately, no thyroid axis being present.

2. *Persistence of the Left Duct of Cuvier, or double superior vena cava.*—This specimen was obtained from a female subject aged about 65. The vein was about the size of a pen-handle, The left vena innominata was not much reduced in size, as is the case when the persistent duct is large. This was the second example of this anomaly that Dr. Shepherd had met with. The left duct of Cuvier persists normally in birds and some mammals.

3. *Dissection of a case of Talipes Varus.*—Dr. Shepherd obtained this specimen from a subject in the dissecting room, aged about 45. The foot had never been operated on, and was a pure case of talipes varus. The deformity was due principally to the contraction of the tibialis anticus, extensor proprius pollicis, and extensor communis digitorum, tendons.

4. *A preparation of an abnormal right obturator artery* given off from the epigastric and passing to the inner side of the femoral ring.

5. *An Inferior Maxilla*, having a large sinus in the body leading down to the decayed root of an incisor tooth.

6. *The Uterus of a Young Girl*, aged about 16, which had the os uteri so narrowed as to admit a fine probe with difficulty.

Progress of Medical Science.

DIAGNOSIS OF LUPUS.

By Dr. McCall Anderson, in *Medical Times and Gazette.*

Lupus Vulgaris.

1. Commences usually before the age of twenty-five, and often much earlier in life.
2. An indolent, painless affection.
3. Edges of patches, though often round and elevated, are soft.
4. Ulcers in most cases superficial, soft, throwing out profuse granulations, and edges often undermined.
5. The nose is the part of the face oftenest attacked.

Epithelioma.

1. Occurs usually in persons getting up in years.
2. Tingling, and pain often lacerating in character, common.
3. Edges hard, everted, and often having a glistening, translucent appearance.
4. Ulcers oftener deep, hard, with uneven, finely granular appearance, and exuding a sticky fluid, which gives a varnished appearance to the surface.
5. The nose is not more frequently involved than other parts of the face.

Lupus Vulgaris.

1. Commences early in life, generally before twenty-five.
2. Often a history of hereditary tendency to strumous affections.
3. Oftenest met with on the face.
4. Ulceration has tendency to throw out profuse granulations, and edges often undermined.
5. Color of eruption yellowish red or violet.
6. Often of many years' duration.
7. Cured by the use of caustics and antistrumous remedies.
8. Often other manifestations of the strumous diathesis.

Late Manifestations of Syphilis.

1. Appears usually after the age of twenty-five.
2. History of syphilis having been acquired.
3. On any part of the body, though often upon the face.
4. Ulceration as if cut out with a punch, and base ash-gray.
5. Color of eruption in the chronic stage usually coppery.
6. Chronic, though not nearly so much so.
7. Cured by mercury or iodine.
8. Generally other manifestations of syphilis.

—*Louisville Med. News.*

NEW TREATMENT FOR GONORRHEA.

A correspondent writes to the *Lancet* concerning what he considers a rational treatment of this common affection. He gives regularly five-grain doses of iodide of potassium, and full doses of cubebs in powder, every three hours. The cubebs in drachm doses he finds rarely fails to cut off the ailment rapidly, and the iodide, besides its solvent influence on the essential element of the powder, has a well recognized action on the various mucous surfaces.

GASTRIC IRRIGATION.

This operation is becoming every day more recognized as useful in suitable cases. Bianchi relates four cases: 1. Chronic gastritis, simulating cancer, pains in the right side, great emaciation, vomiting of food and blood, followed by relief. Many remedies were tried with no good effect until irrigation of the stomach with water at 53.5° or 58° F. was resorted to. The patient felt better the same day. The irrigation was repeated every morning, at first with plain water, afterwards with water containing two drachms of bicarbonate of soda to the quart. The patient was discharged cured in a month, having gained 5 pounds in weight. 2. Chronic catarrh (drunkard's) with probable pyloric stenosis of inflammatory origin. There were pyrosis and vomiting of food, preceded by pain in the epigastrium; cure, in a month. 3. Gastric catarrh, with marked dilatation of the stomach. Great improvement followed in three days, when the patient left. Carcinoma of stomach; fixed pain in the pyloric region, vomiting of blood. The patient experienced much relief from the irrigations, and was able to take liquid nourishment, and gained strength for a time, but died after a month, worn out by the cachexia and debility.—*London Med. Record.*

HOT WATER AS A GARGLE.

Dr. Ritzy has found hot water systematically employed as a gargle of great benefit in overcoming the sensation of rawness incident to acute pharyngitis. He found that the use of hot water paled the red and inflamed mucous membrane more or less permanently. And, so far as unpleasant personal sensations went, it cured the pharyngitis. He also believes that this simple plan of treatment would prove beneficial in diphtheria, in patients old enough to gargle intelligently. In ordinary tonsillitis hot water, he thinks, would hardly fail to act well. The water should be used as hot as can be well borne, and gargling should be practiced for several minutes at a time.—*The Medical Age.*

TREATMENT OF CONSTIPATION IN INFANTS.

Dr. C. T. Renter, of New York, has found a combination of castor oil and glycerine of very great value in the constipation of infants. He gives a half teaspoonful of each at a dose. We notice that this experience conforms to that given by Mr. Wm. Soper in the *Lancet*. Mr. S. regards glycerine as peculiarly valuable through its solvent action on the hardened masses which have accumulated. In chronic constipation, hemorrhoids and anæmia the combination has done good service in hts hands.

Dr. Geo. R. Young, of Belfast, writes to the *Lancet:* A mixture, which is of an agreeable flavor, and in which the nauseous smell of the oil is efficiently disguised, can be made thus:

℞	Ol. ricini.,	ʒ j,
	Glycerinæ,	ʒ j,
	Tr. aurantii.,	M xx,
	Tr. senegæ,	M v,
	Aquæ cinnam.,	ad ʒ ss.

This forms a beautiful emulsion, is easily taken by children, and administered at bedtime will produce a gentle motion the following morning. In cases of habitual constipation, when this mixiure is repeated for three or four nights, it brings about a regular morning motion. The tincture of senega is used to emulsify the oil, and as the quantity employed is small its use cannot be objectionable from a therapeutic point of view.—*Med. Summary.*

SIMPLE TREATMENT OF CONGENITAL CLUB-FOOT.

It is unfortunate that so much of mystery and specialism hangs about the treatment of club-foot. It is too generally thought that it consists solely in tenotomies and the application of complicated and expensive shoes of various kinds which none but the specially initiated can understand. And for this reason cases are often left untreated just when simple treatment would be most quickly successful. For club-foot, like every disease and deformity, is more amenable to treatment in its early uncomplicated stages, and many a case which in later years is cured only after long and wearisome treatment would have been comparatively easily dealt with in its earliest stages. The great objects to be attained in all cases of club-foot are to replace the part in its normal position with the help of tenotomy where necessary, to retain it in that position for a sufficient length of time, and to exercise and stimulate the development of the weakened muscles. This can all be done in congenital club-foot from the earliest days, and ought to be commenced at once. The hand is the proper instrument to correct the deformity, and a plaster-of-Paris splint just strong enough for this

purpose is the best means of maintaining the foot in the proper place. This splint, if made after the Bavarian pattern, can be removed every day for the foot to be rubbed and electricity applied; or the more common form of plaster-of-Paris splint may be removed for the same purpose every two or four weeks. If practitioners would treat their cases of club-foot in this way from the very first, many would be almost if not quite cured before the child began to walk, when the difficulty of treatment is necessarily increased.—*Lancet.*

HÆMORRHAGE FROM THE LACHRYMAL DUCT DURING EPISTAXIS.

Mr. D. Hoadley Gabb, M.R.C.S., of Hastings, describes the following remarkable case:—Mr. S., aged 50, with mitral disease and albuminuria, sat out one of our recent sunny days, and caught a chill, which culminated in an attack of bronchitis and a relaxed state of the fauces and uvula, producing severe spasmodic cough; during one of these paroxysms, epistaxis, from the right nostril especially, came on rather profusely, and I was sent for. There was no difficulty in arresting it by plugging the anterior nares with dry lint. In two or three hours, after a severe cough, the hæmorrhage returned, and a messenger was sent for me, saying the bleeding had come back, and was running out of his nose and eyes; and so I found that the blood had welled up through the right lachrymal duct, and was suffusing his eye, so that he was constantly obliged to wipe it, and the handkerchief was pretty well stained with the blood, and the discharge only ceased when the nose left off. I have never met with the phenomenon before, neither have others to whom I have mentioned it; and so, I think, perhaps it is worth recording."—*British Medical Journal.*

REMEDY FOR CONSTIPATION.

Pulv. aloe	30 grains.
Ext. belladonnæ fl	20 minims.
Ext. nucis vom. fl	30 minims.
Pulv. ipecac	3 grains.
Tinct. gentian comp	2 ounces.
Syr. simp. to make	4 ounces.

M. Sig.—Teaspoonful on the evening of each day when the bowels have not moved. This dose is for adults. For children, five drops for each year of age.

HOT PACK IN PUERPERAL ECLAMPSIA.

Dr. Brens expresses the opinion in the *Arch. f. Gyn.*, that for the cure of puerperal eclampsia, either in the puerperium or the last months of pregnancy, active diaphoresis alone, induced by a hot bath, 40 to 45° C, followed by the pack, is all sufficient. The bath must not be prolonged over one-half hour, and two to three hours suffices for the envelopment in the pack. This method properly carried out, according to Brens, will also cause œdema and albuminuria to disappear without interruption of pregnancy.

OZÆNA.

In several cases of chronic inflammation of the nasal and pharyngeal cavities, giving rise to offensive discharge, Dr. Poore has found decided benefit result from the use of a stimulant and antiseptic snuff having the following formula: biborate of soda, nitrate of bismuth, of each one drachm; disulphate of quinine, ten grains; iodoform, five grains. This snuff has the effect of stopping the fetor and greatly diminishing the amount of discharge from the nostrils. It is liable, as are all snuffs when used for similar conditions, to cake in the nostrils, and it is therefore necessary to thoroughly wash out the nostrils once a day. This may be done by means of a nasal douche, or the patient may easily be taught to snuff a lotion up the nose and allow it to run out of the mouth. A teaspoonful of glycerole of borax dissolved in a wineglass of tepid water forms an excellent wash for the nose, and with a little instruction patients learn how to wash out their nasal and pharyngeal cavities without the aid either of syringe or douche apparatus. In cases where the ozæna is of a simple kind, not due to caries or necrosis of bone, but rather to a sluggish, inflammatory action occurring in a scrofulous subject, considerable benefit is often derived from the administration of the sulphide of calcium in doses of half a grain (in pill), taken three times a day. It is often necessary to cleanse the nasal and pharyngeal cavities with a brush inserted throught the anterior nares, and also behind the soft palate so as to reach the summit of the pharynx. The brush may be moistened with glycerole of tannin, and after the cavities have been cleansed a little iodoform may be passed into the cavities on the tip of the brush.—*London Lancet.*

INFLAMMATION OF THE HAIR FOLLICLES OF THE NOSE.

The St. Louis *Courier of Med.* says: Dr. Hardaway called the attention of the St. Louis Medico-Chirurgical Society to the inflammation of the follicles of the small hairs in the nose. They give intense pain, and there is much inflammation externally as well as within, and very frequently, after the inflammation of the hair follicles subsides, it is followed by *exfoliation* of the outer portion of the skin of the nose; in other words, the patient has a very red nose. Externally, it is generally limited to one or the other side; there is a great deal of sharp, very acute, intense pain. The cases generally continue for weeks, very frequently last several weeks, and when it subsides, there is considerable epidermic shedding—desquamation—showing the

violence of the inflammation. They are cases that try the patience of the doctor and the patient both. Within the last year he has been using a treatment which has given great satisfaction. He uses Squibb's glycerole of the subacetate of lead and glycerine. one part of the first to seven of the latter. Under this treatment, the trouble disappears rapidly.—*Med. and Surg. Rep.*

IODOFORM AS A LOCAL APPLICATION IN FISSURE OF THE ANUS.

The value and efficacy of iodoform in fissure of the anus will bring this remedy into general use in the treatment of this painful and heretofore incurable lesion, without operation by the knife or forcible rupture of the sphincter ani muscle.

It is good surgical practice to cure surgical cases without surgical operation whenever it is safe and praticable; and while it is shorn of its brilliancy and eclat, the fact remains the same, and it is not questioned that conservatism in surgery has been steadily gaining ground, and that the boldest operators are those who weigh well the results before operating.

As in cases involving the greatest danger, so with fissure of the anus—if the trouble can be cured by simple means, without suffering to the patient, and in reasonably due time, the operation of cutting, or forcible rupture, is not justifiable, and both these means of radical cure must give way to the more simple, if such may exist. With the experience I have had in the use of the local application of iodoform in cases of fissure of the anus, I am encouraged to bring the value of this remedy to the notice of the profession in these cases. In their treatment with this remedy, the alvine evacuations should always be maintained in a soft condition; the bowels should never be allowed to become constipated or relaxed; the anus, and parts involved by the fissure, should be kept constantly clean and free from deposit and dry incrustations; and with one or two evacuations a day, the case may be speedily cured by the local use of iodoform. It may be dusted, in *very fine* powder, upon and into the fissured parts, or applied in the forh of ointment or suppository. The application of the simple powders, if properly prepared, three or four times a day, after each evacuation, and in the intervals, is often sufficient. In some cases, however, the undiluted powder—although thoroughly powdered—causes some pain. In such, the iodoform may be mixed with powdered gum acacia, if a powder be preferred, or may be made into an ointment with vaseline, or suppository with the oil of theobroma. Balsam of Peru, carbolic acid, and oil of peppermint, will moderate the intensity of the iodoform odor; but this can hardly be requisite for application in this situation. The application of the remedy may be followed by a little smarting, but soon after its use the sensibility of the parts becomes benumbed, and even defecation may go on without consciousness, so far as concerns the development of pain during or after the process. That this remedy applied as above directed and indicated will cause complete unconsciousness of the act of defecation, I doubt—I have never witnessed such result in any case that has come under my notice, and still the benumbing influence of the remedy is decidedly potent. As in applications to the conjunctival surfaces of the eyelids, the first and most important factor in the successful and painless use of the remedy consists in the proper preparation of the powder. It should be made *very fine*, and not the smallest crystal be allowed to remain unpowdered. The neglect of this precaution when applied to the eye has caused the most painful inflammation of the ocular and palpebral conjunctiva; and applied thus imperfectly powdered to the anus, would likewise cause intense suffering, and as in eye practice, would be abandoned, and declared to be dangerous and valueless, if intelligence did not bring relief.—*Med. and Surg. Reporter.*

A case of relief from intra-cranial abscess by trephining, is reported by Dr. Kilgariff in the *British Medical Journal*. His patient had been thrown while hunting, and had been unconscious for two hours after. At the end of the second week he suffered from much pain over the occipital bone and from gastric irritability. A shallow depression being found over the seat of pain, he diagnosed fracture with formation of abscess. On incising the scalp he found pus, which came through a minute opening in the skull. He removed a button of bone with the trephine and evacuated half an ounce of pus. The abscess cavity was washed out with carbolized water, and the man made a good recovery in spite of erysipelas.—*St. Louis Med. Review.*

An interesting article describing the properties of the new remedy, ichthyol is communicated to the *Deutsch Med, Zeitung* by Dr. P. G. Unna, of Hamburg. It is an easily soluble substance, very volatile, of strong odor, containing a large proportion of sulphur, which on heating readily divides into H_2SO_3, S, etc. It had been in popular use before its employment in diseases of the skin. Dr. Unna has used it in all forms of acute and chronic rheumatism, and considers it an antirheumatic of first rank, there being no other external remedy of similar efficiency. He uses it with vaseline in a strength of ten per cent. and more, brushed on the painful joints twice daily, and keeps the limbs in the meantime wrapped up in cotton. It has an analogous action with horses suffering from stiff joints, as has been reported by several veterinary surgeons. It has also been employed with benefit in lumbago, bronchial, nasal and laryngeal catarrh (inhalation of two per cent. solution), and in angina it is applied either with the brush or as spray. In parasitic diseases of the skin it is of

benefit. The doctor has not yet employed it internally, but thinks it indicated in mild catarrhs, in hemorrhoids and parasites of the intestines. Of the undesirable action of ichthyol the writer mentions a general and local hyperhidrosis. It tends to increase the thickness of the skin, hence its beneficial effect in eczema, and so produces eruptions of miliaria. To counteract this the doctor recommends the powdering of the parts after applying the remedy, to facilitate the rapid absorption of perspiration, or by adding mildly macerating preparations, such as lime, for instance: ℞ Ichthyoli, 10.0; ol. olivæ, ap. calcis, aa 100.0. M.S.—To be well shaken before using, or, make a pause and intercurrently use warm baths made by means of sand, spent tan bark or white bolus, with the addition of a little soda. *St. Louis Review.*

Ichthyol (Monatsh f. Pract. Dermat.) is a substance which looks like tar, has a peculiar herbaceous odor and is of the consistency of vaseline. It is partly soluble in alcohol, partly in ether, and wholly in a mixture of both. It can be mixed with vaseline or fat in any proportion. It contains a large per centage of oxygen and ten per cent. of sulphur. The healthy skin is not irritated by it, while it has a very beneficial effect in all forms of eczema, and is to be used in gradually weaker strength as the eczema heals. In grown persons with papulous eczema it may be used as strong as fifty per cent. at first. The itching and pain are relieved, and soon the surface becomes drier and paler. It may advantageously be combined with salts of metals, as it does not form any sulphur derivatives with them. Ichthyol is made from a bituminous mineral, found in the vicinity of Seefeld in Tyrol. The color of the rock is light to dark brown, it contains from ten to sixty per cent. of bitumen. In the neighboring layer a great many impressions and petrefactions of fish are found, so that the Geologist, Prof. v. Fritch, expressed the opinion that the bitumen contains the remains of antediluvial marine animals and fish. At any rate, from this discovery the preparation derives the name ichthyol. The mineral is subjected to a dry distillation, and a tarry product obtained, which, after careful cleansing, is treated with concentrated sulphuric acid; the sulphate produced is the substance under consideration. *St. Louis Med. Review.*

THERAPEUTICS OF THE THROAT.

By A. N. Ellis, M.D., Lecturer on Laryngology, Cincinnati College of Medicine and Surgery.

Gentlemen:—In speaking of the special and general treatment of diseases of the throat I will pass over the latter very briefly. Before going further I shall call attention to the fact that the morbid conditions which underlie all affections of that important region are but few. Take away syphilis, tuberculosis and that which comes in the train of the eruptive fevers, and we have very little left on which we may dwell long in speaking of the application of remedies for the purpose of building up the system or of eradicating constitutional vices or weaknesses. Hence the most of this paper will be given to the consideration of topical remedies and the use of different instruments. Time flies so rapidly that it seems but yesterday since Prof. Tuerck first used the laryngoscope in the Vienna hospitals, yet in that short space of time wonders have been done in detecting and remedying the defects and diseases of the human voice. Light has been thrown into dark places, slight changes have been readily diagnosed, growths, ulcerations, swellings, thickenings, deformities and abrasions are seen at a glance, and thus every appliance of science is brought to the aid of the most useful and fascinating specialty in the whole domain of medicine and surgery.

When Helmholtz invented the ophthalmoscope he opened the realm of a new world. Four years later came Tuerck, with the laryngoscope, and the voice of the dumb broke forth into songs of thanksgiving when set free by the skillful hand of our God-given art!

In speaking of the medication of the throat I shall pre-suppose a ready and complete knowledge of the throat-mirror, for without making ourselves master of that little instrument we may as well content ourselves with a simple tongue-depressor, and throw in general treatment after the crude old-fashioned way.

I shall speak of gargles, lozenges, inhalations, fumigations, pigments, sprays and douches. The limits of this paper will prevent my noticing, as I would like to, dietetics and hygiene. Ever keep in mind that in all specialties, as in general practice, our therapeutical methods must be adapted to the exigencies of our cases. Age, sex, constitution, individual and family history must all be taken into account. When we remember the great importance of the throat—that we must all breathe and swallow in order to live—slight changes in form and the presence of certain growths and inflammations are of the greatest moment, for upon this condition of things very often hang the issues of life and death. The age in which we live is one that demands accurate scientific knowledge. What we know we must know well; and what we are to do, must be *done at once*, and with the greatest judgment, knowledge and skill. Many a valuable life has been snuffed out in a moment by a transient œdema, which might have been relieved by a trifling operation. The most terrible scene in the life of the illustrious Washington was the short hour when he choked to death for want of a hand to save him!

I. Gargles.—Gargles have always held a prominent place in all works on the throat. They are as popular as they are time-honored, yet after all they are of very little use, for they scarcely ever penetrate behind the anterior pillars of the fauces

I will not deny that they are very good mouth-washes, and as such prize them for their antiseptic and astringent qualities. Do not understand me as denying their valuable properties, but do not forget at the same time that very few persons ever learn to gargle properly. I have heard of some people who could go so far as to let the fluid penetrate into the larynx, yet have never seen such a patient in my own practice. Of course in the case of children this class of remedies is not to be thought of.

II. LOZENGES.—I look upon this form of preparations as the most valuable we have at our command. When we come to speak of lozenges, the American pharmacopœia is almost poverty-stricken when compared with those of other countries, for in Europe they are more skillfully prepared and much more used than in this country. They are generally small, dry, solid masses, usually of flattened shape, consisting for the most part of powders incorporated with mucilage and sugar. They are to be held in the mouth and dissolved slowly in the saliva, and are therefore well adapted for the administration of remedies which do not require to be given in large quantities, and are destitute of any very disagreeable flavor. One great recommendation in favor of troches is that they are convenient, and I look for the time to come when the throat specialist will be armed with many of his drugs in this shape. Here we get not only an immediate local effect, but also the constitutional action of the drug, and this is often greater in proportion than if a corresponding amount had been taken direct into the stomach. Guaiacum may be instanced as an example of this.

One great drawback to the use of lozenges is to be found in their hardness, their consequent slowness to dissolve, and their liability to produce erosion—inconveniences which may be obviated by incorporating their ingredients with fruit paste which not only renders them more palatable but also facilitates their dissolution. Right here permit me to call attention to their effects upon the stomach and their liability to interfere with digestion. The U. S. Dispensatory contains 14 formulæ for lozenges, one of the most valuable of which is that of morphine and ipecac (in the proportion of $\frac{1}{36}$ of a grain of the former to $\frac{1}{12}$ of the latter) in the treatment of an irritable and painful cough. The troches at the Golden Square Hospital are, with the exception of those containing carbolic acid and marsh mallow, all made of fruit paste, tragacanth and a small quantity of refined sugar. I have often thought that one reason why Morrell Mackenzie has such great success in his specialty is due to the fact that he gives the strictest personal attention to the purity and elegance of his preparations.

III. INHALATIONS.—These are subdivided into vapors, sprays and fumigations. We cannot give too much praise to this class of remedies, for it includes the most reliable and effective methods of applying remedial agents to the throat and larynx. From earliest time the inhalation of vapors has been a recognized means of medication. In the treatment of bronchitis, asthma, and other pulmonary affections the inhalation of watery vapor impregnated with stramonium, hyoscyamus, camphor and substances of the same class, has been found a useful means of allaying spasm and irritability of the bronchial tubes. During the last decade great strides have been made in the application of remedies to the diseased mucous membrane of the air passages, which has been attended with the most gratifying results.

(*a*) VAPORS.—Vapors are of two kinds, aqueous and volatile, and these may be further subdivided into moist and dry, and the former into hot and cold—hot when the temperature ranges from 130° to 150°, and cold when it is from 60° to 100°. Dry inhalations should always be hot, *i.e.*, heat must be applied in order to vaporize certain volatile matters. Of course it is understood that a suitable inhaler should be used.

Inhalations are employed for their action as antiseptics, antispasmodics, hæmostatics, resolvents, stimulants and sedatives. Truly a wide range of application, and hence the remark just made in regard to their value. The best time to administer them is before meals. If hot vapor is used, every precaution should be taken against the danger of taking cold, and for this purpose the patient should not go out of doors for at least 30 minutes. In the case of cold inhalations this precaution is not necessary; indeed it is very often the case that the use of a cold inhalation will procure for the patient an immunity from catarrh which he had not previously enjoyed. Morrell Mackenzie, at the Golden Square, Prosser James, at the North London Consumption Hospital, and Lennox Browne, at the Central London Throat and Ear, all make use of volatile oils—the oil being held in suspension in water by means of light carbonate of magnesia in proportion of one-half a grain of the mag. to one minim of oil. These are divided into sedatives, antispasmodics and stimulants. Of the strong stimulants, liquor ammonia, vapor of chlorine and iodine are at the head; speaking further we have a list of milder ones, beginning with carbolic acid and running down through camphor, cinnamon, cubebs, creosote to juniper and pinus sylvestris. Of the sedatives, chloroform, ether, benzoin, conium and lupuline are the most trustworthy. Although very inconvenient on account of its bulk, the old inhalation made by macerating hops in hot water is very soothing.

Of the antispasmodics we may briefly mention, hydrocyanic acid, ether and nitrite of amyle. It is best to reduce these inhalation mixtures to a uniform standard of one ounce—a teaspoonful to a pint of water at a temperature of 140° constituting an ordinary dose.

The vapor should be inhaled by means of deep, full inspirations—five or six to the minute, kept up for ten minutes—twice a day. Be careful when

using ether, chloroform and nitrite of amyl, as some persons are so very sensitive to their action as to become giddy and faint in breathing in a very small quantity. Sometimes I have seen these effects from one drop of chloroform in a pint of hot water. Generally speaking, it is such a powerful remedy that we never realize the danger of using it until some sad accident has thrown its shadow across our path. Dry hot inhalations are of the greatest value in many cases of excessive catarrhal secretion.—*Cincinnati Clinical Brief and Sanitary News.*

McDANIEL'S METHOD OF ARTIFICIAL RESPIRATION.

It is said that for upward of a hundred years after the publication of his Principia, the University in which Newton toiled continued to teach in accordance with views thought to be true up to the time of the enunciation of his. If this be so—we could hope for the honor of humanity that it is not—what a significant commentary is it upon the conservatism, the prejudice, the apathy, in a word, upon all the traits that go to bind men down to grooves previously cut and fashioned for them.

Many instances of like kind might be mentioned, if one were not enough to serve our purpose.

In this issue of this Journal there is a brief review of Esmarch's lectures on aids in injuries and accidents, in which attention is called to the fact that, in resuscitating persons apparently drowned, reference is only made to the methods of Hall and Sylvester, while that of McDaniel is, it would seem, either unknown or ignored.

McDaniel's method of artificial respiration is really best suited to the cases of still-born (not dead) infants, but we think with the author, that it is at the same time the best means of reviving respiration without regard to cause. This being the case, it is high time that men like Esmarch should know that there is such a thing as "McDaniel's Method." If it is not the case, it is then high time that the "Method" should be known of men, and given its proper place as a scientific procedure.

We do not see, however, why the method is not already known, for Dr. McDaniel invited the attention of the medical public to it so long ago as 1869, in a paper read before the American Medical Association, and published in the transactions of that body for that year. He also read an elaborate paper on the same subject before the Alabama State Medical Association at its annual meeting in 1879, which can be found in the transactions for that year. From this it is evident that Dr. McDaniel has not hidden his light under a bushel; notwithstanding, it is apparent from an editorial in the *Philadelphia Medical News* of Aug. 12, 1882, that its learned editor knows nothing of McDaniel's claims.

In regard to the validity of these claims, it is proper to say in this connection that they were submitted by appointment to a committee, selected from among the ablest medical men in Alabama, and, after mature test and deliberation, substantiated and acknowledged.

Dr. McDaniel does not propose to set aside all other methods of artificial respiration "but," as he says, "merely to introduce into general practice a new one of very great efficacy, very safe, of very convenient and speedy application, very easily comprehended, and especially adapted to small patients."

Without further comment, we will now quote from Dr. McDaniel's last paper, only premising that enough favorable reports have been made in the cases of new-born infants to challenge the attention of the profession.

"After," says the author, "the invention of the spirometer, by Hutchinson, it was soon ascertained that the capacity of the chest is greater in the erect form than in any reclined or recumbent position. This is a great fact for physiology, for the diaphragm is a piston whose pump motion varies the chest capacity and causes an ingress and egress of air. In the recumbent position the liver and other contents of the abdomen press upon the diaphragm and diminish the chest capacity. In changing from the recumbent to the erect position, this pressure is gradually removed and the chest capacity is increased. It is obvious that all that is necessary to cause air to enter the lungs is to change the patient from any recumbent or any inclined position to the erect one; and all that is necessary to cause the air to pass out of the lungs is to move the patient back from the erect to any inclined or recumbent position. But I have discovered that the increase of capacity in the chest is slow and small in moving from the recumbent position to an elevation of forty-five degrees, and rapid in ascending from forty-five degrees to the erect position. It is therefore not essential in practicing artificial respiration to move the patient through the whole range from recumbency to erectness, but is sufficient to use only the upper half of this range, merely moving the patient from a forward inclination of forty-five degrees to the erect position and back again. *Every upward and backward movement produces an inspiration and every forward and downward movement an expiration, and the two together a complete respiratory act. By regularly repeating these acts, artificial respiration is rhythmically performed, and can be prolonged at will.* Any one will find that if he leans forward from the erect position to an inclination of say forty-five degrees, he will mechanically and involuntarily expire, and if he moves back to the erect position he will mechanically and involuntarily perform inspiration. He cannot, by any power of volition, prevent the result or reverse it. *This simple movement upward and backward to the erect position, and*

downward and forward to a sufficiently inclined position, regularly repeated, constitutes my proposed new method of artificial respiration.—The New Orleans Medical and Surgical Journal.

TREATMENT OF URTICARIA.

Dr. G. H. Fox, of New York, read a paper on the treatment of urticaria, in which he stated that the treatment must vary with the cause of the disease. When dependent upon a gouty diathesis, such remedies as carbonate of sodium and colchicum were proper, with abstinence from meat and nitrogenous food. In gastro-intestinal disturbances, rhubarb, bismuth, and sulphurous acid were indicated.

Flatulence was often the only sign of indigestion. In a case of obstinate urticaria with frequent relapses, treated, according to the suggestion of Dr. J. M. Da Costa, of Philadelphia, with sulphurous acid with alkaline baths at night, a notable improvement occurred on the second day, and a cure, without subsequent relapse, was accomplished by the end of the second week.

Drugs which acted upon the nervous system, such as quinine and others, had both caused and cured urticaria. Some patients were intolerant of quinine, and invariably suffered from use of it.

Dr. F. D. Lente had noted cases of malaria ushered in by premonitory urticaria. In one peculiar case the urticaria appeared every evening at seven o'clock, and was cured by ten-grain doses of quinine.

Belladonna and atropine had been used in doses sufficient to produce flushing of the face. The reader—Dr. Fox—had seen less benefit from atropine than belladonna.

Salicylate of sodium in doses of one grain every hour had relieved the disease, but larger doses had more frequently produced it.

The use of arsenic had given rise to contradictory reports. Bromide of potassium had been effective. Drop doses of copaiba had been used in vain by himself as well as others.

The use of these various remedies, and of half-drachm doses of ergot, showed that the treatment of urticaria was empirical, and the good results reported were often attributable to careless observation and to self cure. The proper treatment depended upon the etiology.

Dr. Rochester stated that he had seen a good deal of urticaria, and had found that an emetic such as ipecac, was much more efficacious than other remedies. It was possible that diaphoretic action had something to do with it. He had a patient upon a simple milk diet, taking four or five quarts a day, with much benefit.

REVIVAL OF BLOOD-LETTING AS A THERAPEUTIC RESOURCE.

In the Paris letter to the *Lancet*, the views of two of the most prominent practitioners of that city with regard to blood-letting are referred to as follows: "Professor Peter, who was one of Trousseau's most fervent disciples, and present editor of his clinical work, employs venesection on rather a large scale, particularly in cases of apoplexy and epilepsy, in which Professor Trousseau condemned it altogether. At his clinical meetings, and in his lectures at the School of Medicine, Professor Peter teaches that, with all deference to his former master, he has found by experience that blood-letting, if judiciously employed, is invaluable in some cases, and apoplexy is just one of those in which it would be found useful. As in the days before the publication of Professor Trousseau's clinical works, Professor Peter practices blood-letting at the moment of the attack, with the hope of cutting it short, and he does so at a later stage with the view of facilitating the reabsorption of the clot of blood formed at the seat of the lesion, and to moderate the congestion in its neighborhood. On the strength of this theory, Professor Peter, at his clinic, lately bled a patient who was upwards of sixty for an attack of apoplexy and hemiplegia of the left side, and he declared, at a meeting of the Medical Society, that this bleeding had been the means of saving the patient from imminent death. He employs general depletion even in the convulsions following apoplexy, with great benefit to the patient, as he had noticed that, notwithstanding the presence of a large quantity of albumen in the urine, the convulsions and the albumen had entirely disappeared after a small bleeding from the arm. Professor Vulpian employs blood-letting in its various forms in all cases of inflammation, and he has found it invaluable in peritonitis, whether from puerperal or other causes. At the Clinique d'Accouchement, Professor Depaul scarcely employs anything else in puerperal convulsions. He bleeds the patients largely and repeatedly until the most urgent symptoms are relieved, and he has frequently stated at the Academy of Medicine and at other medical societies that the results of the practice that he has carried out for more than a quarter of a century can bear comparison with any other method of treatment adopted by other physicians in similar cases; in fact, the mortality among his patients has always been considerably less."—*Med. Times.*

AN ADDRESS ON THE ANTISEPTIC TREATMENT OF DISEASES OF THE LUNGS.

Delivered at the Inaugural Meeting of the West London Medico-Chirurgical Society.

By I. Burney Yeo, M.D., F.R.C.P., Physician to King's College Hospital, etc.

Gentlemen:—When your secretary, Mr. Keetley, did me the honor of inviting me to bring

before this Society the subject of the Antiseptic Treatment of Pulmonary Diseases, I confess I at first hesitated to accept that invitation. I felt that although I had given some attention to the subject my time was at this moment so fully occupied that I should not be able to deal with the subject so fully and completely as its importance merited, or as was due to a Society so learned and influential as yours. I also felt that it was a subject which was only just beginning to be looked at from something like a firm scientific standpoint, and that from this point of view the question of the antiseptic treatment of diseases of the lungs was in its initial stage—a stage certainly full of suggestions for future investigation; but the work of examination, of experiment, of comparison, of testing, and of criticism—serious, helpful criticism—for the most part has yet to be gone through. It might then, I thought, seem premature to introduce this subject to this Society for discussion in its present stage; but when I reflected on the intrinsic importance of the subject itself, when I thought of the vast interests, direct and collateral, involved in its discussion, and of the power and influence the members of such a Society as this would possess in collecting evidence bearing upon it, I yielded to your secretary's request, relying on your kind indulgence to excuse the merely suggestive character of this address and the many shortcomings and defects which future research alone can supply. It is remarkable when we begin to look into the history of almost any subject, how little there is that is new in its facts and its phenomena. What is new resides in our mode of regarding them, our comprehension of them, our application of them. The truth is always there in the facts and phenomena of nature, but it is often only discovered after ages of observation, of experiment, and of opposition. Of opposition: how remarkable is this spirit of opposition! how remarkable has it been in the history of one of the latest and greatest triumphs and discoveries in the art and science of surgery, the antiseptic system. As if the work of discovering truth in this universe was not hard enough, men are perpetually encountering from their fellow-men the most ardent opposition in this task. In proof of what I say I need only point to the present agitation on the part of a well-known Society against all experiments on animals—a Society which, reversing the exclamation of the dying Goethe for "more light," might be fittingly designated "The Society for the Maintenance of Darkness."

The idea of an antiseptic treatment of pulmonary diseases is certainly *new* in our present mode of regarding it, in our comprehension of the phenomena with which it is concerned, and in the extended application which we propose to give to it. But the thing itself is not new, the phenomena are not new. The adoption and the success of antiseptic methods of treatment of pulmonary affections have been recorded again and again, and they have, again and again, met with opposition, and not rarely with a sort of sneering contempt. This, gentlemen, you may be satisfied will never be the case again, and for the following reason: Hitherto, or till quite lately, such efforts were empirical, and without any strictly scientific basis, but now our antiseptic methods are founded on scientific knowledge—on principles, principles that have been evolved from a series of most patient, and at the same time most fruitful, investigations, which will go far to make this latter half of the nineteenth century the most illustrious in the history of medical science. A very few historical illustrations will suffice to prove what I have said about the antiquity of the fact of the antiseptic treatment of pulmonary affections. Hippocrates and Galen used to advise the inhalation of balsamic vapors in pulmonary affections, and the latter used to recommend phthisical patients to settle in the vicinity of Vesuvius and Etna, where they could inhale sulphurous vapors as well as sea air. But we will confine ourselves to the history of pulmonary therapeutics during the last hundred years, and one of the most noticeable facts in this period is the frequency with which tar vapor has been advocated as of great value in the treatment of lung diseases. Dr. Rush of Philadelphia in 1787, Dr. Beddoes in this country, about the same time, and Sir Alexander Crichton in 1817, all stated that they had met with great success in treating cases of phthisis by inhalation of the vapor of boiling tar, and Dr. Solis Cohen, in his excellent book on "Inhalations" in connection with this testimony, says: "The use of tar vapors in phthisis deserves to be fully and systematically studied, so that safe indications may be laid down as to the character of cases to which it is most applicable." Between 1819 and 1830 the French physicians, Gannal and Cottereau, and Sir James Murray in this country, reported excellent results from the treatment of cases of phthisis with dilute chlorine vapor. One of these had noticed that the workmen in bleaching factories with chest disease visibly improve, and another reported thirteen cases of phthisis cured by inhalation of chlorine, and Louis in Paris, and Dr. Elliotson and A. T. Thompson in London, spoke well of it.

In 1835 Sir Charles Scudamore became an enthusiastic advocate for the inhalation of iodine vapors in phthisis, and after ten years' experience of its use he expressed himself as convinced of its remedial power. Piorry (between 1850 and 1860) also was an advocate for the continuous inhalation of iodine vapor in phthisis, and for this purpose he used to have several saucers containing iodine placed about the patient's pillow. He treated thirty-one patients in this way for two years; twenty were decidedly benefited, both as regards symptoms and physical signs; in seven cases both symptoms and physical signs disappeared, and four cases died. Later still Skoda used inhalations of the vapor of turpentine with much success in phthisis, pulmonary gangrene, and in catarrhal affections of the air passages.

I have selected these few illustrations almost at random from the history of pulmonary therapeu-

tics to prove to you that I was right in saying that there is nothing new in the facts, and they also go towards disproving the statement that I have lately seen made by one or two writers in the journals of the small amount of success that has attended the antiseptic treatment of phthisis.* I suppose I have as much right to speak on this subject as any of those writers, for during ten years I saw personally over 27,000 applicants in a hospital devoted to the treatment of this affection, and of all the methods of treatment of which I have had any knowledge or experience, those into which some antiseptic measure entered as an important element were certainly attended with the best results. The difficulty, however, always was to secure anything like a proper application of an antiseptic agent; and after trying various devices for this purpose, I at length devised a very simple method of continuous inhalation, which answers the purpose better than any other with which I am acquainted. I have described this elsewhere,† and you can examine the specimens of the little apparatus I have devised for this purpose that are on the table.

Let me here make a remark which, as practical men, you will at once see the force of. It is useless to attempt to test any method of treatment by applying it to cases of advanced phthisis. In such cases the mischief is done. No antiseptic agent will cause numerous suppurating cavities to close up and heal, or replace lung tissue that has been destroyed by progressive ulceration and disintegration, or remove extensively disseminated tubercular and inflammatory infiltrations. And yet how many cases of phthisis come before us already in this state. It is greatly to be regretted that certain physicians should ever have pretended to have cured such cases, and that others should seriously have tested their statements by the application of any special method of treatment to cases so advanced and so hopeless. In order that any case may be cured by any method of treatment the first and essential condition is that it should be curable. And cases of phthisis too often come for the first time under our observation long after the possibility of cure is passed. But the question for us to examine and to satisfy ourselves about now is this. Is an antiseptic system of treatment applied to lung diseases true in principle?

If we can convince ourselves that the principle is a true one, modes of application and developments in practice will be certain to follow. In the first place, then, let us inquire, What is antiseptic treatment? Antiseptic treatment applied to the lungs is one or both of two things: First, it is the prevention of a hurtful, poisonous (septic) agent getting to the lungs from without; and, secondly, it is the destruction, or the limitation of the action of a hurtful, poisonous (septic) agent already within them.

And now let us ask ourselves if there is any *à priori* reason why it should not be possible to satisfy both these indications. It was argued warmly not many years ago, as a necessary preliminary to this discussion, that it was impossible to bring medicinal agents into contact with the pulmonary surface by inhalation. This argument has been abundantly disproved by the most varied and elaborate experimental investigations.*

So, then, supposing a hurtful septic agent to exist in the lungs—and in phthisis the presence of such an agent has been demonstrated beyond all question, and its virulently septic quality established—the problem of the antiseptic treatment is this: Do we possess, or can we discover, any agent which we can convey, in the form of gas, vapor, or solution into the lungs which shall be inimical to the life and activity of this septic body? Or can we place our patient under any possible conditions of life which shall prove hostile to its growth and development? It would be illogical and absurd in the extreme to deny the possibility of such a method, or of the discovery of such an antiseptic agent, if we do not not already possess one or more. The second indication must therefore be admitted to be quite possible. Now, let us turn to the first indication. It is not only necessary to destroy any septic agent that may be already in the lungs, but we must be able to prevent septic agents from entering them with the respired air. Now, this may be accomplished in two ways: (1) We may place our patient in an atmosphere which by examination we know to be absolutely pure and free from septic particles; or (2) we may diffuse through the air he breathes an agent hostile to the life and activity of any septic particles there may be in it. This, again, is a true antiseptic treatment, and it is certainly possible in either of these two forms. If then we limit ourselves (which we had better do on this occasion) to the consideration of the treatment of phthisis, we have two things satisfactorily proved. First, there does exist a hurtful specific septic agent in the lungs. Second, an antiseptic treatment is possible. There is no beating the air in this. Gentlemen, we are here on sure and certain footing; we have reached a principle. This is only the first stone of the edifice we have to build, but it is the foundation stone. The next thing for us to do is, by patient labour in the way of observation and experiment, to apply this principle. Our object is to discover what agents there may be within our reach capable of being administered without inflicting injury to the pulmonary tissues, which may have the power of destroying or neutralizing or arresting the activity of the septic organism, which seems to be the operative cause in the origin and propagation of phthisis. I am disposed

*In my recently published Lectures on Consumption I have collected a mass of contemporary testimony in favor of this treatment.

† Lectures on Consumption. London: J. & A. Churchill.

* Vide Oertel: Respirator schen Therapie.

to believe that other common forms of diseases of the respiratory organs have a septic origin also, and call for antiseptic treatment, but we must for the present concentrate our attention on this subject of phthisis.

Already we have abundant and incontestable proof that pure air—pure, cool dry air, in unlimited amount—is such an antiseptic agent. Wherever such air is found—on the high table land of Mexico, in the elevated valleys of Switzerland, on the Kirghiz steppes of Asiatic Russia, in the pine forests of Central Germany, and on the open sea—wherever men live a life in the open air, away from the emanations of cities, and from too close contact with humanity—in all such places we hear of consumption becoming arrested and cured. The bacillus tuberculosis seems to love hot, moist air, and air freely charged with the exhalations of humanity; warmth and moisture seem to provoke it into special activity, while dry air at a comparatively low temperature seems to be inimical to it. Whoever has watched, as I have done, a large number of cases of phthisis in this country, must have been struck with the frequent occurrence of rapid advances in the disease during the first warm moist days of spring and early summer.

And here again I am tempted to quote a passage to which my attention has been recently called by my friend, Dr. Frank, of Cannes, to show how true it is that the facts we are discussing are not new. It occurs in a very able book by a German writer, "Hausrath on New Testament Times," an English translation of which has been published by Williams and Norgate. He is alluding to the mountain air of the fortress of Masada, a mountain fortress on the borders of the Dead Sea, where John the Baptist was imprisoned. There he says, Josephus tells us provisions retained their freshness for over 100 years "because the air at the altitude of the fortress was purified from all earthly and corrupt particles!" It is precisely such air—air purified from all "corrupt particles"—that we require for our phthisical patients; and if we cannot send them where such air is naturally found, we must artificially create for them an antiseptic atmosphere which they can breathe where they are; and if we are to perpetuate consumption hospitals, it is with such an atmosphere we must fill them. But the time will probably come when instead of crowding a number of consumptive patients together in the centre of a populous district of a crowded city, we shall acquire for the same purpose a good-sized pine wood with a dry subsoil a few hundred feet above the sea level, and build a certain number of scattered cottages through the wood, and hang up a number of hammocks between the fir trees and send our consumptive patients there to be aired into health! In wet weather they would make up fires of fir wood and pine cones, and so fill their cottages with balsamic and antiseptic vapors; and with open windows and a dry soil they would find the wet weather less injurious to them there than in towns. But we have other antiseptic resources more manageable than a pine wood. And here let me call your attention to the peculiar anatomical conditions of the respiratory organs, by which they are rendered peculiarly prone to septic attack, and pecially needing of antiseptic defense. The lungs is the only deep-seated internal organ in the body which is freely accessible to the surrounding air. Perpetually the outer air is passing in and out of the lung, and thus septic particles in the air can readily reach the pulmonary surface, which is most richly supplied with absorbent vessels. But if, owing to the anatomical disposition of the parts of the lung, septic bodies can readily reach it from without, for the same reason antiseptic particles can also be readily brought into contact with it, either in the form of gas or vapor or fine spray and mist or even fine solid particles.

It is needless to offer you any proof of this. You will, I take it, all except this statement as proved; and you are no doubt familiar with various forms of apparatus devised for the purpose of carrying out such applications. But though we may sterilize or destroy in this way such germs or microbes as may commonly occur in the surrounding atmosphere, and so purify and render harmless the air that passes in and out of the lungs in respiration, it does not follow that the agents we now know to be germicines, such as carbolic acid, eucalyptol, thymol, etc., and which are used by surgeons on account of that property, are necessarily destructive of the tubercle bacillus. Analogy would lead us to conclude they might be, and the experience of their use in the hands of many competent observers* tends to strengthen this view. But we must not rest satisfied with this; we must pursue our studies of the life history of the tubercle bacillus until we have discovered what is the particular agent or agents which are especially inimical to its development and activity.

There is another difficulty which we must be prepared to encounter—the difficulty of inducing patients to submit to a continuous process of disinfection. It is by no means easy to induce phthisical patients to wear, almost continuously, even so light and simple an appliance as the one I have shown you, and it would be infinitely more difficult to get them to inhale a spray for many hours a day, supposing it should be discovered that the best antiseptic is soluble in water but not vaporizable at ordinary temperatures, as was the case with the benzoate of soda of which so much was expected by some. But I believe this difficulty would almost entirely disappear if our knowledge became absolutely precise, and our confidence in our remedy completely assured. If we could say to our patients "by this means you will be cured, and by no other," this difficulty would, I am persuaded, almost cease to exist. Hence, however, we see the obvious advantage of being able to re-

* Lectures on Consumption, Appendix to Lecture 2.

move our patients to an antiseptic atmosphere where they cannot help inhaling the curative agent continuously.

And now I must bring these merely suggestive observations to a close. In the foregoing remark I have chiefly endeavored to show that the idea of an antiseptic treatment of lung diseases is based on scientific data, and that in principle it is established as a truth. What lies before us is to overcome the difficulties in its application. We should be encouraged in this work by the thought that whatever progress we are enabled to make we shall be furthering the labors of the great experimental pathologists of our times, the labors of men like Pasteur, Koch, and Lister. It is not given to every one to be enabled to work with a genius and an energy like theirs. But let me remind you that one of them—Koch—was a country doctor, a general practitioner, like many who are here to-night; and we may all do something toward transferring the influence of their intelligence and their genius, and in applying the fruits of their labors to the practical daily duty of healing the sick; and in spite of much disingenuous misinterpretation and foolish abuse we may be able to prove to the world that experimental pathology is in the very highest degree beneficent and philanthropic. For the first time we seem to have grasped a principle in the treatment, both preventive and curative, of a class of diseases which we have hitherto regarded almost with despair. Let us steadily work on the foundation which this principle supplies, the successful application of which must be attended with immense service to humanity and lasting honor to medical science.—*Brit. Med. Jour.*

SOME NEW DISCOVERIES IN REGARD TO ERYSIPELAS.

In a paper read before the Cincinnati Medical Society (*Lancet and Clinic*), Dr. Joseph Eichberg gives a resumé of a treatise on the etiology of erysipelas by Fehleisen, of Berlin, which treatise he regards as another step in the gradual perfection of our knowledge of the disease. He refers to the various theories of the causation which have obtained, beginning with Galen, who referred the cause to disturbances of the biliary secretion, and continuing down the line to Huter, who advanced the theory that the erysipelatous virus belonged to the class of micro-organisms. Subsequent investigations have confirmed the theory by demonstrating the presence of micrococci and bacteria. The author differs from Huter, who considers the virus to be small micrococci in active movement, while he lays special emphasis on the fact of their immobility.

Fehleisen's experiments succeeded in isolating the erysipelas micrococci and in propagating them by culture, producing in this manner in the course of two months, fourteen generations. In the manner of their growth they presented peculiarities which at once enabled him to distinguish them from the micrococci of pyæmia and other affections whose germs are morphologically identical with those of erysipelas. The inoculation of rabbits with these artificial culture fluids produced a disease absolutely identical with erysipelas. Patients in the hospital were also inoculated with identical results. In selecting patients for these experiments a double purpose was sought to be accomplished. Remembering the frequent mention in the literature of the subject, of the favorable influence exerted by a concurrent attack of erysipelas in cases of neuralgia, typhoid fever, acute rheumatism, chronic diseases of joints and various forms of syphilis, lupus and many neoplasms, five of the patients selected for the experiments were affected with morbid growths and two with lupus. In six of the seven cases erysipelas was promptly developed; the seventh case had had numerous previous attacks of erysipelas, the last occurring but three or four months previously, and was supposed to have thus established a tolerance for the virus. Without considering each of these cases in detail, it may be stated that the development of erysipelas in no case did harm, while in three the therapeutic effect was quite satisfactory. Such inoculations are, however, permissible only when hope of benefit from operative interference has passed.

Aside from their therapeutic effect, these experiments are worthy of consideration in deciding the question of the origin of erysipelas. All cases were types of pure erysipelas as determined by Bergmann, who examined them all in common with many of his colleagues of the Wurzburg clinic. In regard to the researches of Lukomsky, Billroth, Ehrlich and Tillmans, who found the micrococci in the lymphatics of the skin and subcutaneous fat, and in the blood-vessels, liver, kidney and substance of the heart, it may be safely presumed that in these cases there was a complication with pyæmia or lymphangitis or phlegmon; in the uncomplicated affection the micrococcus is found only in the lymphatics, which is characteristic of the affection. The spread of the disease does not occur, as in lymphangitis, along the course of the lymph stream, but the dissemination takes place in all directions, frequently against the direction of the lymph current.

With reference to the spread of the disease in any community, there can be no doubt that it is contagious, *i.e.*, transmissible from man to man by direct contact, through the use of instruments, etc., but this is not the only or even the usual method of its dissemination. On the contrary, no reasonable doubt can be entertained that the micrococci multiply and generate outside of the human or animal body. Moreover it is not an easy matter to produce an artificial erysipelas without resorting to the method of cultivation outside of the human body. Many experiments of direct inoculation from man to man have given negative

results, which proves that the danger of contagion from a person suffering with erysipelas is not very great. The bacteria, which have entered the body, disappear almost as quickly as they multiply, without ever reaching the surface, and thus having opportunity to act as the means of secondary infections. The micrococci of erysipelas would then very speedily disappear altogether were there not some soil in which they might develop, other than the human body. As pointing to such a conclusion, there may be cited the fact that in artificial cultures they multiply when cultivated upon potatoes, as well as upon coagulated blood serum or gelatin.

Another interesting feature of the experiments bears upon the question of immunity from second attacks. After a primary inoculation, seven persons were vaccinated; six were affected with erysipelas; the seventh patient had frequently been affected and had passed through his last attack a few months prior to the experiment. Of the six other successful vaccinations, two were repeated several times. The third case, successfully, on the 7th of October; subsequently on the 1st and 9th of November, unsuccessfully. In case No. 5 patient had erysipelas in December, 1881; on the 7th of October, 1882, she was successfully vaccinated with the culture virus; on the 9th of November, thirty-three days after this, the vaccination was unsuccessful. We may conclude from this that one attack of erysipelas confers an immunity of short duration from later attacks.

The author concludes his paper by reporting some experiments made with a view of testing the effect of two antiseptic agents upon the disease germs. The two agents were those used for the dressing of wounds in Bergmann's clinic, a one-per-cent. solution of corrosive sublimate and a three-per-cent. solution of carbolic acid. After exposing the germs on a platinum wire to the action of the carbolic acid for twenty seconds, no apparent effect was produced, for the artificial cultures developed as rapidly and extensively as before. An exposure of thirty seconds caused an imperfect and retarded development of the cultures; and an exposure of forty-five seconds destroyed them altogether. The solution of corrosive sublimate destroyed them much more quickly, an exposure of ten to fifteen seconds being sufficient to prevent their development on gelatin. As showing the value of antiseptic dressings, suggested by these experiments, the author cites the statistics of the surgical clinic of Bergmann, where, during a period of four and a half years, erysipelas occurred only in two cases treated with the antiseptic dressing, and he adds, this very limited number may be ascribed to some slight defect in the dressings; and, when it is remembered that erysipelas is of very frequent occurrence in Wurzburg, these figures show decidedly in favor of the antiseptic method. When it is further remembered that many cases of operations about the face and head, where the antiseptic dressing was not applicable, were, during the same time attacked with erysipelas, any additional proof seems unnecessary. The antiseptic dressing will, however, only prove efficient when its application has been preceded by careful disinfection of the wound and of surrounding parts; for this purpose strong solutions of carbolic acid answer best, as they penetrate somewhat into the tissues around the wound, without, at the same time, coagulating the albumen of these tissues; an objection which militates against the employment of corrosive sublimate.

As far as erysipelas is concerned, the labors of Fehleisen seem to decide conclusively a great deal that has hitherto been only speculation and surmise; and, with reference to completeness, are really more satisfactory than the valuable discovery of Koch which they so briefly follow. How far the future physician is to benefit by this work in the field of therapeutics it were possible to conjecture. It is the first time that artificial culture fluids have been successfully used for the production of disease in man, and the very success which has crowned these efforts will probably serve as an encouragement to many to follow in the path which the author has so brilliantly indicated. We can only hope for the sake of humanity and of our science, that those who may come after shall, like Fehleisen, bring to their work scientific acumen, clear observation, and, above all, over all, a sincere desire to relieve suffering and ameliorate distress. —*The Medical Age.*

THE HUMORS OF EXAMINATIONS.

(*From Chambers' Journal.*)

It is related of a rough-and-ready examiner in medicine, that, on one occasion, having failed to elicit satisfactory replies from a student regarding the muscular arrangements of the arm and leg, he somewhat brusquely said, "Ah! perhaps, sir, you could tell me the names of the muscles I would put in action were I to kick you!" "Certainly, sir," replied the candidate; "you would put in motion the flexors and extensors of my arm, for I should use them to knock you down!" History is silent, and perhaps wisely so, concerning the fate of this particular student. The story is told of a witty Irish student, who, once upon a time, appeared before an Examining Board to undergo an examination in medical jurisprudence. The subject of examination was poisons, and the examiner had selected that deadly poison, prussic acid, as the subject of his questions. "Pray, sir," said he to the candidate, "what is a poisonous dose of prussic acid?" After cogitating for a moment, the student, replied, with promptitude, "Half an ounce, sir!" Horrified at the extreme ignorance of the candidate, the examiner exclaimed, "Half an ounce! Why, sir, you must be dreaming! That is an amount which would poison a community, sir, not to speak of an individual!" "Well, sir," replied the Hibernian. "I only thought

I'd be on the safe side when you asked a poisonous dose!" "But pray, sir," continued the examiner, intent on ascertaining the candidate's real knowledge, "suppose a man did swallow half an ounce of prussic acid, what treatment would you prescribe?" "I'd ride home for a stomach-pump," replied the unabashed student. "Are you aware, sir," retorted the examiner, "that prussic acid is a poison which acts with great rapidity?" "Well, yes," replied the student. "Then, sir, suppose you did such a foolish thing as you have just stated," said the examiner; "you ride home for your stomach-pump; and on returning you find your patient dead. What would you, or what could you, do then?" asked the examiner, in triumph, thinking he had driven his victim into a corner whence there was no escape. "What would I do?" reiterated the student. "Do?—why, I'd hould a post-mortem!" For once in his life that examiner must have felt that dense ignorance united to a power of repartee was more than a match for him.

Incidents of a highly ludicrous nature frequently occur in the examination of patients, both by doctors and by students. A Professor on one occasion was lecturing to his class on the means of diagnosing disease by the external appearance, face, and other details of the patient. Expressing his belief that a patient before the class afforded an example of the practice in question, the Professor said to the individual, "Ah! you are troubled with gout!" "No, sir," said the man; "I've never had any such complaint!" "But", said the Professor, "your father must have had gout!" "No, sir," was the reply; "nor my mother either!" "Ah, very strange!" said the Professor to his class. I'm still convinced that this man is a gouty subject. I see that his front teeth show all the characters which we are accustomed to note in gout." "Front teeth?" ejaculated the patient! "Yes, retorted the professor; "I'm convinced my diagnosis is correct. You have the gout, sir!" "Well, that beats everything," replied the man; "it's the first time I've ever heard of false teeth having the gout! I've had this set for the last ten years!" The effect of this sally on the part of the patient, upon the inquisitorial professor and his students, may be better imagined than described.

Occasionally within the precincts of colleges and universities a rich vein of humor may be struck in a very unexpected fashion. On one occasion a professor, noticing that certain members of his class were inattentive during the lecture, suddenly arrested his flow of oratory, and addressing one of the students, said, "Pray, Mr. Johnson, what is your opinion of the positions of the animals just described, in the created scale?" Mr. Johnson was forced to say that "really he had no views whatever on the subject." Whereupon the professor, turning to a second inattentive student—who had evidently not caught Mr. Johnson's reply or its purport—said, "Mr. Smith, what is your opinion of the position of these animals in the classified series?" "Oh, sir," replied the innocent Smith, "my opinions exactly coincide with those just expressed so lucidly and clearly by Mr. Johnson?"

There are examiners and examiners, of course; some stern, others mild and encouraging. The student, who, when asked by a stern examiner what he would recommend in order to produce a copious perspiration in a patient, replied, "I'd make him try to pass an examination before you, sir!" had a keen sense of humor, which it is to be hoped the examiner appreciated. His answer was in keeping with the question which has been argued by us and by others, whether the whole subject of examinations, as at present conducted, should not be thoroughly overhauled and revised,

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MICRO-ORGANISMS AND TUBERCULOSIS.

The April issue of *The Practitioner* is entirely devoted to a report to the "Association for the Advancement of Medicine by Research on the Relation of Micro-Organisms to Tuberculosis." The researches of Klebs, Toussaint, Schuller, Koch, and others are discussed historically and critically. The methods of Toussaint and Koch were made the subject of personal investigation, and visits to their laboratories at Toulouse and Berlin, with the results of a large number of physiological experiments, are likewise included in the report, which is further illustrated by some beautiful colored plates representing microscopic sections of diseased structures, and showing the grouping of the tubercle bacilli. Dr. Cheyne says, in conclusion,—

"A consideration of all the facts has led me to the conclusion that tuberculous processes in the lungs are due to the tubercle bacilli, and, so far as I know, to them only. By a tuberculous process I mean one where there is proliferation of epithelium, caseous degeneration of this proliferated epithelium, and inflammation round about, these changes being progressive. It has been supposed that inhalation of dust of various kinds may give rise to phthisis. That the inhalation of dust will lead to inflammatory changes is very likely, that it may lead to proliferation of epithelium which may subsequently degenerate is possible, but that the process will be progressive and extend beyond the seat of irritation is not probable. That the changes set up by the presence of gritty particles may, however, prepare the lung and render it a fit soil for the implantation of bacilli is very probable, and in this way a true tuberculous process may supervene, not due to the original gritty substances, but to the bacilli which came afterwards. I have only had the opportunity of examining three cases of potter's phthisis and one of miner's phthisis. In the former there was, histologically,

a true tuberculous structure, and there the tubercle bacilli were found. In the case which was labelled miner's phthisis, but the details of which I did not obtain, there was fibrous formation, the fibrous tissue being very vascular, and there was no appearance, histologically, of tuberculous structure, nor were any bacilli present.

"As to the intestinal ulcerations which often occur in phthisis, and which are supposed to be due to swallowing sputum, I have only examined two cases, and there I found tubercle bacilli in the wall of the ulcer bearing the same relation to epithelioid cells and caseous matter as elsewhere.

"As to heredity of tubercle, I would call attention to the case of the guinea-pig, which was highly tuberculous and which had an almost fully developed fœtus in its uterus (Experiment XVIII., p. 289). The fœtus and placenta were healthy and free from tubercles.

"It has often been urged that the milk of tuberculous cows is infective. This may be the case when the mammary glands become tuberculous; and the mode in which the bacilli might get into the milk is well illustrated by the appearances which I found in the kidney of rabbit No. 1. (Experiment XIV., p. 286.) There not only were bacilli present in the tubercular mass, they were also found in large numbers in the epithelium of the kidney-tubules, and in the interior of the tubules, both in the immediate vicinity of the mass and at some distance from it. I have not yet had an opportunity of examining an early tubercle of the kidney, but, from what I have seen I think it quite likely that the epithelium of the tubules may in some cases be the primary seat of the bacilli in the kidney, just as the alveolar epithelium is in the lung. In that case bacilli would be present in the urine not merely when there were marked tubercular masses in the kidney, but also where the disease was but slightly advanced, here again resembling the case of the lung. From analogy I suppose that the same is the case with the mammary glands, and that bacilli might be present in the milk even though the disease of the gland is not sufficiently far advanced to be noticeable."

IODINE BLISTERS IN TABES MESENTERICA.

In tabes mesenterica, Dr. Bouchut, of the Children's Hospital, recommends the application of blisters, or the tincture of iodine, upon the abdomen, and if ascites were present tapping should be employed without hesitation. The *regime* to be followed should be very severe—beef-tea, eggs, raw milk, and claret. If diarrhœa be present, enemas of borax, one drachm each time, should be given, and three or four teaspoonfuls of glycerine in the day, by the mouth. Bismuth, or phosphate of lime, would be very useful. Your correspondent tried this treatment in an apparently hopeless case, and a rapid recovery ensued. The disease was far advanced, and the child was abandoned by its ordinary medical attendant.—*Medical Press.*

TO ABORT A STYE.

Dr. Louis Fitzpatrick, who has recently returned from Egypt, where all kinds of eye affections are extremely common, writes to the *Lancet* that he has never seen a single instance in which the stye continued to develope after the following treatment had been resorted to: The lids should be held apart by the thumb and index finger of the left hand (or a lid retactor, if such be at hand), while tincture of iodine is painted over the inflamed papilla with a fine camel's hair pencil. The lids should not be allowed to come in contact until the part touched is dry. A few such applications in the twenty-four hours are sufficient.

SUBCUTANEOUS INJECTION OF QUININE.

The following solution when injected hypodermically has frequently proven of service in obstinate cases of neuralgia; it should be injected close to the painful point:

℞.	Quiniæ bromhydrat,	1 gram.
	Æther. sulphuric,	8 grams.
	Sp. vini rect.	2 grams.
M.		

ANEURISM OF ANTERIOR COMMUNICATING ARTERY.

In presenting a case to the Medico-Chirurgical Society of Montreal (*Medical News*, March 3, 1883), Dr. Osler called attention to the fact of the frequency of aneurism of the cerebral vessels, and to the fact that many cases of apoplexy in young persons were caused by them. This was the eighth instance which had come under his observation in the past few years.

SPECIMENS OF RENAL CARCINOMA.

Before the Midland Medical Society (*British Medical Journal*, March 24, 1883).

Dr. Windle showed a large deposit of carcinoma in a left kidney, secondary to scirrhous mammæ of two and a half years' duration, the patient being a female, aged 62. This was the only secondary deposit existing. After removal of the breast, very little urine was passed, and none at all the day preceding death. The fatal termination occurred six days after the operation.

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SUBINVOLUTION OF THE UTERUS.

A very valuable lecture on this subject by Dr. Clinton Cushing, of San Francisco is to be found in the *Med. News*, June 2, 1883. He considers premature assumption of domestic duties, after parturition as one of the most frequent causes of this unfortunate condition, and he formulates the following sound advice to physicians:

"If it is possible to do so, I know of no better investment of time and money than for a woman who is raising a family to devote at least a month following her delivery to rest and quiet, and as free from excitement of any kind as may be. Unless she is confined to her bed by poor health, it is the only opportunity a mother of a family has to remain quiet longe nough to get really rested; and I would advise you to inculcate, in the most thorough manner, the minds of your puerperal patients with the idea that a full month must be given up to rest and recuperation after delivery, and that a portion of each day after getting out of bed must be spent upon a lounge or couch for several weeks. Of so much consequence do I consider this advice, that I would again urge you to use all your eloquence to show your patients the advantages to be derived from a month's bodily and mental rest following confinement.

LANCING THE GUMS OF CHILDREN.

After stating that it is proper to lance the gums when they are swollen and either red from inflammation or white from pressure of a tooth *coming*, Dr. Chase, in the *Mo. Dental Journal*, goes on to say:

"The operator should *know* whether a tooth is pressing on the gum, and trying to make its way out. In this case, *cut down to the new tooth*, until it is felt under the lancet. For incisors and cuspids, a straight line cut. For molars, a crosscut.

"How *not* to do it: Not with a child sitting up, in your lap, or any one's lap.

"*How* to do it: Let the operator and "nurse" sit close together, facing each other. The child is laid down face upwards; the head in the operator's lap, the feet in the "nurse's" lap. The nurse holds the limbs of the child quietly, so that it may not interfere.

"With the left hand the operator takes the jaw between his fingers, and slowly and firmly does the cutting.

"There is no false cut. The child is still."

TREATMENT OF GONORRHŒA.

A rather large number of American, German, French and English physicians have—as we see by reading through the many different foreign and domestic medical journals—of late been reporting very successful results in the treatment of gonorrhœa by the *yellow* oleum santali. We learn that the remedy invariably puts an end to the discharge within two days, but to prevent a relapse it has to be continued for two weeks longer. From 15 to 20 drops given three times daily is the usual dose which may be administered on sugar or in gelatine capsules.

OXIDE OF ZINC IN CHRONIC DIARRHŒA.

M. Gubler has found it most useful in the diarrhœa of phthisis, and whenever ulceration of the uterus is suspected. He gives it in powders in the following form: Oxide of zinc, thirty grains; bicarbonate of soda, ten grains; in four powders two or three daily.

TINEA VERSICOLOR.

Tineaversicolor or *Liver Spots* is an exceedingly common affection, and one that causes much annoyance, since the patient frets at having this blemish on his skin. To cure it, Dr. George H. Rohé (*Med. Record*, June 2, 1883,) recommends a lotion of hyposulphite of sodium, half a drachm to the ounce of water. The patient is directed to take a bath once a day, using soap freely. After the bath the affected spots are to be mopped with the parasiticide lotion. In a week the discoloration has usually disappeared. The remedy should be continued a week or two longer to prevent relapse. Dr. Rohé says it is surprising to what an extent cases of tinea versicolor are treated for syphilis, hepatic derangement, or similar supposed affections of the internal organs. Patients are

sometimes compelled to take mercury or potassium iodide for months, under the supposition that they suffered from syphilis, when the only trouble was that just described, which, when properly treated, yielded to local remedies alone in the brief space of two weeks.

PERSONAL.

Dr. Fenwick of London, Ont., brother of Dr. Fenwick of Montreal, has been appointed to represent the Medical Faculty of Western University, in the Ontario Medical Council.

Dr. Stephen, (M.D., McGill, 1880) has been elected on the Montreal Dispensary staff in place of Dr. Macdonell, resigned.

Dr. O. H. E. Clarke (M.D., McGill, 1870) has removed from Cohoes, N.Y., and located in St. Louis, Mo.

Dr. Edmund Christie (M.D., McGill, 1882) son of Dr. Christie of Lachute, has settled in Chicago.

Drs. McLean and Duncan (M.D., McGill, 1881) and lately resident medical officers at the Montreal General Hospital, have entered into partnership and commenced practice at Fergus Falls, Minn.

Dr. Chandler (C.M., M.D., Bishops, 1881, and Wood Gold Medalist) was in Montreal early this month on a visit. Dr. Chandler has been elected (after examination) surgeon to the Charity Eye Hospital of Boston. He intends devoting his attention entirely to ophthalmology.

Dr. Robert J. B. Howard, son of Dr. R. P. Howard of Montreal, has passed the primary examination for the fellowship of the Royal College of Surgeons, England.

Dr. McLean, formerly of Kingston, Ont., and lately of Ann Arbour, Mich., has removed to Detroit, having been appointed surgeon to the Michigan Central Railroad. He has resigned his Chair of Surgery in the Universityof Michigan.

Dr. T. A. Rodger, Point St. Charles (M.D., McGill, 1866) has been appointed Medical officer to the Grand Trunk Railroad in place of Dr. W. E. Scott, deceased. We congratulate Dr. Rodger, and assure him that his numerous friends have heard of his appointment with great pleasure.

Dr. Houston (M.D., McGill, 1881) has become a Benedict, and was in Montreal on his marriage trip early in June. He is practicing at Cohoes, N.Y.

Dr. McNiece (M.D., McGill, 1867) has located in Montreal.

Dr. Thompson (M.D., McGill, 1881) now stationed at Matawa, as one of the Medical officers of the Canadian Pacific Railroad, was in Montreal for a few days this month. He reports a considerable surgical practice in his division.

CORRESPONDENCE.

To the Editor MEDICAL RECORD.

SIR,—May I draw the attention of your readers to the very large sale in the Dominion of what is technically termed Commercial Citrate of Iron and Quinine. It appears to me very absurd for physicians to purchase a drug only because it is cheap, and even some hospitals are guilty of buying the cheapest drugs on the market. If there is one place more than another where the very purest qualities of everything pertaining to drugs should be found, most assuredly it ought to be the hospital, so much depended upon by the profession for accurate and exhaustive therapeutic experiment.

This cheap citrate of iron and quinine, containing only some 5 per cent. of quinine and in some cases no quinine at all, is evidently sold to somebody; can it be possible that physicians who give their own drugs to their patients, buy it? I scarcely think it possible that any druggist in Montreal would be so dishonest as to dispense prescriptions with it.

Citrate of iron and quinine is an article of the British Pharmacopœia and it is this preparation which is intended when prescribed. Even the product of the very best makers, such as Howard and Huskisson, appears, according to the best analysts, such as Gerard, to be usually below the standard—not intentionally so, but perhaps owing, as Mr. Wood says, to a change of composition when exposed to the sun's rays, or it may be that chemical analysis is a little at fault in determining the precise quantity of the alkaloid present. Be that as it may, there are articles on the market containing not more than 1 or 2 per cent. of quinine. Such preparations should never be purchased, and only those should be allowed in any drug store which bear the maker's name and guarantee label.

Let us hope that spurious citrates are not allowed through the Custom House at a lower rate of duty than the correct article. It seems to me every ounce of citrate of iron and quinine passing through the Customs should be understood to be the true officinal article and charged accordingly.

Now that we have an experienced chemist and druggist as appraiser let us hope he will look out this matter.

Truly yours,

HENRY R. GRAY.