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Original Communications.

IS EARLY RESECTION OR CONSERVATIVE TREATMENT ADVISABLE IN COXITIS?*

BY HERMAN MYNTER, M.D.,

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While our increased knowledge of the pathology of tuberculous joint affections has resulted, in most joints, in earlier operations in order to remove the local focus before the joint has become totally disorganized, the same cannot properly be said about tuberculous affections of the hip-joint. We still find the same disagreement between the adherents of conservative and operative treatment, and I scarcely say too much when I state that in the vast majority of cases excision is still made as *ultimum refugium* only. Yet even in these cases a better knowledge of the pathology and consequently improved operative methods have been followed by decreased mortality and improved functional results. In order to decide the question, it seems proper shortly to study the pathology of coxitis. We formerly believed that tuberculous affections of the hip, or for that matter of any other joint, commenced as diffuse inflammations, which went on to destruction of the joint. *Post-mortem* examinations were rare, except in cases which represented the later stages of coxitis. In these the synovial membrane was always found diffusely diseased, the ligaments and the perisynovial tissue changed to gelatinous, oedematous or fibrous tissue, the joint itself filled with fungus granulations, the cartilages generally ulcerated and shed, leaving the epiphyses in a state of softening and caries. But often we found the cartilages more or less intact and we therefore believed that the synovitis

was the primary lesion, the disease of bones and cartilages secondary. The tuberculous bacillus was unknown and we supposed a dyscrasia present. Furthermore, all acute infectious diseases were known to be followed occasionally by inflammations of the joints, which always commenced as a synovitis, as in pyæmia, puerperal fever, typhus, scarlet fever, etc. It was acknowledged that the inflammation occasionally might commence in the bone, but it was believed that it even then commenced as diffuse inflammation of the medullary tissue in the epiphyses.

We overlooked that these diffuse processes, whether in bone or in synovial membranes, were secondary and were the result partly of an infection, partly of reactive and reparative processes.

It is the Germans, particularly the late Prof. Volkmann and Prof. Koenig, both of whom I quote extensively in this paper, to whom belongs the credit of proving that the fungous or tuberculous joint affections commence, in the majority of cases, as a local focus in the bone and that the consecutive entrance into the joints of the *materia morbi* from the local focus produces the diffuse inflammation of the synovial membranes and the epiphyses. That the disease, in a few cases, may commence as a synovitis is not denied and is occasionally proved by *post-mortem* examination.

This is by no means a generally accepted theory. Habernern, for instance, states that in 132 cases of excision a primary osseous lesion was present 80 times, 23 times a primary synovial affection, while the starting point was doubtful in 23 cases. Watson Cheyne thinks the disease more often primarily osseous, although not in the proportion Habernern states. The trouble is that only in early cases can the presence of a local focus be shown. In late cases we find exactly the same changes in bone and joint, whether the disease started as an osseous or synovial inflammation.

It is therefore probably true that the vast majority of cases commence, as Volkmann says, as an osteitis and not as an arthritis, and more particularly as a circumscribed cheesy or tuberculous osteitis or osteomyelitis.

It depends upon circumstances whether the joint later becomes attacked: viz., whether the products of the inflammation perforate into the joint, as usually, from anatomical reasons, occurs, or seek the surface. The primary focus, at least

* Read before the Ontario Med. Association, June, 1891.

in childhood, is always in the bone, either central or near the peritoneum. Generally only one focus is present and it is rarely the case that both epiphyses are attacked simultaneously.

The focus is generally small, as large as a cherry-pit, or at most as a nut. The neck is the point of predilection in the near neighborhood of the epiphyseal cartilage, or in the diaphysis, or trochanter major, while the head is rarely the starting point. The focus may perforate the epiphyseal cartilage in order to invade the epiphysis. It may even commence as a chronic osteomyelitis in the cavity of the femur and work its way upwards. Primary attacks of the acetabulum are probably more frequent than generally believed. Habernern states, that in his 80 cases the acetabulum was attacked alone in 50 cases, the femur alone in 23 cases and both together in 7 cases.

The focus presents itself as a little cavity filled with cheesy granulations and bone detritus and frequently a sequestrum, and surrounded with a pyogenic tuberculous membrane. Sequestra were present 51 times in Habernern's 80 cases, soft caseous deposits 29 times. If the focus perforates into the joint, tuberculous synovitis occurs with very acute symptoms. If the focus is in the neck or trochanter major, the joint occasionally escapes, the osteitis and abscesses being extra capsular.

While the osteitic process is going on in the neck and before perforation takes place, we may discover changes in the joint itself. The synovial membrane, the periosteum and the periarticular tissue become more or less infiltrated and œdematous, slight exudation may occur and a partial obliteration of the joint may take place; little by little the whole synovial membrane may be changed into a granulation tissue, and yet we have no tuberculous arthritis. When at last the perforation occurs, it is into a half obliterated joint, and the symptoms are therefore proportionately less; as a joint reacts the more severely to infectious products when the synovial membrane is physiologically intact, and the less severely the more the synovial membrane has been changed into a granulation tissue. This partial obliteration we meet particularly in the knee-joint, but less often in the hip-joint, where we consequently are more apt to meet acute suppurative arthritis. Yet even here we occasionally see a central necrosis of the head and neck being followed by an obliteration of the

joint, and thereafter destruction of the epiphyseal cartilage and diastasis of the head, which meanwhile has become firmly attached to the acetabulum. As a rule, the hip-joint is attacked early, as the whole neck, in which the local focus generally is found, is inside the synovial capsule, but we may see the joint escape even when the focus starts as a central necrosis in the head or neck. A carious fistula may then be found perforating outward through the trochanter major. This point is of importance as indicating the way in which such a central necrosis may occasionally be attacked, through trephining of the trochanter and the neck, or by ignipuncture.

The perforation of the tuberculous local focus having occurred into the healthy or half obliterated joint, further pathological changes take place, while at the same time the symptoms of coxitis, which so far have been vague and insignificant, become pronounced on account of the implication of the synovial membrane, the cartilages and adjacent Haversian canals. The characteristic symptoms are particularly the starting pains and the muscular contractions, both indicating osteitis in the neighborhood of the joint cartilages, while the position of the limb (adduction, flexion and rotation) is less characteristic, probably depending upon other causes.

The pathological changes are those of a tuberculous synovitis, with its resulting destructive processes.

The round ligament, which is covered with synovial membrane, is early attacked and softened, and then disappears.

The osteitic process generally commences at the place of insertion of the round ligament to the head and acetabulum, and on the neck at the place where the synovial membrane is attached. The cartilages become ulcerated by pressure of the granulations (Volkmann's ulcerative decubitus), or shed by pressure of the granulation-tissue, meanwhile developed in the dilated Haversian canals. The bones are now in a state of osteoporosis; the head loses its roundness and becomes smaller from pressure, just as the acetabulum enlarges by pressure upwards and backwards, or becomes perforated by gradually developed decubitus, and spontaneous dislocations and intra-pelvic abscesses result. Periarticular abscesses are rarely the result of the breaking down of granulation-tissue in the peri-

articular tissue. They occur usually from softening and perforation of the capsule itself. So much in regard to the pathology. Yet I wish at this stage to show a pathological specimen which to the fullest illustrates the pathological process as here described. The patient is a little girl ten years of age, who entered the Sisters' Hospital in Buffalo in March, 1891. She had then been sick only two weeks, and a physician had opened up an abscess on the outer side of the right femur. Contra-openings were made in the hospital and the abscess found to be situated beneath the vastus muscles, but apparently not connected with the hip-joint which seemed healthy. Two weeks after entering the hospital she grew worse and offered the usual symptoms of coxitis. Under chloroform, the joint was examined and a carious process found on the upper side of the neck. A good sized abscess was found in the pelvis and opened. As this abscess was supposed to indicate perforation of the acetabulum, I removed the head and neck, which I here show. You see a local focus in the neck which had opened into the joint, the synovial membrane of which was found thickened and tuberculous. The round ligament had disappeared and at its place a carious process is going on. The cartilages are yet healthy. I suppose the carious process on the upper surface of the neck gave occasion to the first abscess, and that the tuberculous focus perforating into the joint produced the acute symptoms of coxitis. In this case the excision was performed about four weeks after the beginning of the disease.

In another case, operated at the same time, the disease had lasted two months. I found there a sequestrum in the neck, three-quarters of an inch long, a perforation into the joint, shedding of the cartilages, osteitis of the epiphysis, diastasis of the epiphyseal cartilage and tuberculous synovitis. In both cases the operation cut short the disease, the wounds healed rapidly and the final result will be what I have always obtained: a movable joint with some shortening, which is easily overcome by aid of a thick sole. I consider this specimen of peculiar value, as showing the condition in the early stage. In later resections, in which we find diffuse osteitic processes of head, neck and trochanter major, destruction of cartilages and tuberculous degeneration of the synovial membrane, it is impossible to find the local focus, as everything

is diseased, but that does not prove that it was not present in the start.

Coxitis may, under favorable conditions, terminate in recovery in any stage, of course with more or less deformity; and the usefulness of the limb depends upon the amount of flexion and adduction. A perfect recovery with normal joint is rarely obtained. I myself remember only one case. And with what cost is this imperfect recovery with a more or less deformed limb obtained? It means years of suffering and treatment, be that with extension in bed or with a portable apparatus, frequent operations for abscesses with resulting fistulas, the dangers of amyloid degenerations of liver and kidneys, and of tuberculous meningitis, and, lastly, of an excision as *ultimum refugium* at a time when neither the broken-down constitution of the patient nor the extensive destructive processes in head, neck and shaft favor reparative processes. In those cases in which we do not have an abscess, the tuberculous focus has probably become encapsulated, surrounded with a zone of sclerotic bone tissue, and the synovial membrane is not tuberculous, although the joint may be partially or totally obliterated. In these cases conservative treatment is probably indicated. But if abscess is present, it shows that perforation has occurred, and, in my opinion, an early operation is the only thing that can arrest the disease.

And yet, why wait for abscess? The tuberculous bacillus, as is well known, is not a pyogenic bacillus, and may, under favorable circumstances, continue to grow and infiltrate surrounding or more distant tissues. If abscess occurs, the pyogenic bacteria, particularly the staphylococcus pyogenes aureus, will always be found present as the cause of the suppuration. The chronic pathological process has only become complicated by the acute suppuration, and the tuberculous process keeps on advancing simultaneously with the suppuration.

It must not be forgotten that the statistics of resection must be compared with the statistics of those conservatively treated cases, in which abscesses were present. In both classes we find a great decrease in mortality in our time.

Leisink, for instance, gives a mortality of 63 per cent. after resection, of which 22 per cent. succumbed to wound complications; 21 per cent. to marasmus; 11 per cent. to phthisis; 7.5 per

cent. to anyloid degeneration, etc. A more recent English statistic of 320 cases showed a mortality of 40 per cent. Jacobson has increased Leiszink's statistics of 176 cases to 250 cases, and finds a mortality of 40 per cent. The result of conservative treatment was even worse. Of 63 conservatively treated cases in Copenhagen, 73 per cent. died, and 27 per cent. recovered. An English statistic of 384 conservatively treated cases, in all of which abscesses were present, showed a mortality of 67 per cent., a recovery of 33 per cent.

If abscess was not present, 69 per cent. recovered. Grosch (1882) found a mortality of 28 per cent. under antiseptic treatment.

Koenig states in a recent work, that it is an exception that a patient dies after resection of acute or chronic sepsis. In spite of the decreased mortality following resection, surgeons still differ in regard to the advisability of conservative or operative treatment. Two English surgeons of large experience, Marsh and Wright, represent well the different opinions. Marsh is strictly conservative, and considers excision uncalled for. Continued rest, he says, gives a mortality of only 5 per cent., and 70 per cent. recover, with slight lameness and loss of motion. Even when suppuration has occurred he gives a mortality of only 6 and 8 per cent.

Dr. Wright, on the other hand, with an experience of more than one hundred cases of excision, of which only three died as a result of the operation, strongly advocates excision as soon as external abscesses occur, yes, even before the capsule has been perforated. He maintains that excision cuts short the disease, saves pain, lessens time of treatment, and gives a better functional result. Osteomyelitis once established, nothing short of excision can, in his opinion, prevent the progress. Nature can, of course, get rid of the caries and necrosis, but the children who can survive the elimination are few, except among the well to do. The decreased mortality and the better functional result are the result of our increased knowledge of pathology and improved operative methods. Formerly we simply excised the head and perhaps neck and trochanter, but we left the tuberculous synovial membrane and discredited the operation, because, as might be expected, suppuration continued or increased, and our patients died of marasmus, amyloid degenerations, tuberculous meningitis or phthisis.

Modern pathology has taught us that coxitis is primarily an osteitis, secondarily a tuberculous synovitis and arthritis, and that it is necessary not only to remove the bone affection, as we formerly did, but to remove the tuberculous synovial membrane just as well. If anything is left of that, relapse is sure to occur. The same is true about the tuberculous pyogenic membrane covering an abscess. If all diseased tissue of bone and synovial membrane is removed, we may get healing of the wound by first intention even, just as we see it in operations on the knee-joint. I am even inclined to go a step farther than Wright, and advocate still earlier operation in order to remove the local focus before diffuse inflammation of bone and joint has occurred. I tried this shortly ago in the case of a little girl, who had been sick six weeks and who had considerable infiltration around the neck. I made an anterior incision (Barker's) between the sartorius and tensor vaginæ femoris muscles and exposed the neck with ease, the extensor quadriceps femoris being pulled inwards. I found under this muscle a great mass of tuberculous material, which had not yet broken down into pus, and removed it, but I could not find the local focus, although by flexing the hip-joint I could examine the whole lower surface of the neck. I closed the wound with sutures and it healed by first intention. She did not improve, and three weeks after I resected the joint, found a sequestrum 3-4 inch long near trochanter and a completely disorganized joint, diastasis of the epiphyseal cartilage, etc. The patient left the hospital recovered in three weeks. I show you the preparation here.

Mr. W. H. Battle reports a similar case in the London Clinical Society. He successfully removed the local focus, washed out the joint, and the child recovered in four weeks.

If the disease commences in the acetabulum (and according to Habernern this should occur in 5 out of 8 cases) operation would be still more indicated as the dangerous complication of intra pelvic abscess is apt to follow. This complication has formerly been considered an absolute indication for resection, but Bardenhener, of Cologne, has several times resected the acetabulum in such cases, by aid of his symphyseal incision (extraperitoneale explorations-schnitt). But even if it is possible, yes, comparatively easy, to resect the

acetabulum in this way, we are forced to leave behind the tuberculous synovial membrane, and the secondarily affected head and neck of the femur, and the disease, I judge, would proceed in spite of this operation.

Still one question remains, whether the limb is better after excision or after conservative treatment?

Holmes thinks that shortening is generally greater after excision and the limb less firm and less useful. Motion is more frequently present and more extensive, but the patients walk more insecurely and with more limp. Jacobson thinks the average results obtained by conservative treatment superior to those following excision, particularly in adults, where we often get flail-joints after excision.

Wright, with his large experience, thinks that excision gives better results and that much shortening depends upon using the limb too early.

It is evident that the best result following excision cannot compare with the best result following conservative treatment: *restitutio ad integrum*. We must compare those conservatively treated cases, who have got well in spite of abscesses, caries and years of suffering, with those, in which, for the same reasons, excision was made. Few get well by conservative treatment, extending during years, without considerable flexion and adduction. To treat such a case demands such continual patience from both the parents, the patient and the surgeon, that a good functional result is almost out of the question unless the patient be treated in a hospital, where the surgeon has complete control over the patient and the nurses. It might, therefore, more properly be asked, whether a flexed and adducted limb is more useful than a shortened limb after resection?

Judging from my own limited experience I believe that excision gives a better functional result and a better looking leg than does conservative treatment in the majority of cases, particularly if you can sever the bone above the trochanter minor. If you are forced to go below the trochanter minor you are very apt to get a flail joint. In early, or comparatively early operations, the disease will probably always be found confined to the head and neck.

I have, during the last few years, resected the hip-joint ten times, eight of which recovered with

good and useful limbs; two died of other causes, independent of the operation.

The earlier the operation has been done, the better has the functional result been and the quicker the recovery. The last two cases, the pathological specimens of whom I have shown here, left the hospital with healed wounds in three or four weeks, but have, of course, not yet been allowed to use their resected limbs. Most of the cases presented themselves in the third stage of coxitis with extensive carious destruction, large abscesses and broken down constitutions. Yet even these cases, which had been treated conservatively for a long time, were, by prompt excision, restored to health and comfort, and provided with a firm and useful limb.

FATTY TUMORS IN THE INGUINAL CANAL. *

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A group of fatty tumors has been described as occurring at the groin, in the inguinal canal, and in the scrotum, situated beneath the deep fascia of the neighborhood and devoid of any peritoneal covering. The mode of origin of these tumors has been the subject of considerable discussion, and on more than one occasion it has been suggested that they were developed from the extra-peritoneal fat. That layer of fatty tissue lying outside the peritoneum bears much the same relation to the serous membrane as the subcutaneous fat bears to the skin. We often find fatty tumors developing in the subcutaneous tissue, and we are not surprised to meet with similar growths occurring in the subserous fat; they are certainly not so common in the latter situation as they are in the former. When the appendices epiploicæ are much enlarged and form tumors of considerable size, we have in them a good example of subserous lipomata. Bland-Sutton* figures clusters of pedunculated fatty fringes occurring along the colon, to which he has applied the term "Lipoma Arborescens." Another specimen

* Read before the Ontario Med. Association, June, 1891.

* *British Medical Journal*, vol. I, 1890, pp. 878, 879.

of a pendulous lipoma of the colon is also described in the same paper.

It appears that some cases of so-called ventral herniæ are not true herniæ. In a true ventral hernia we have some of the abdominal contents protruding through the anterior portion of the belly wall, it may be through the linea alba or the rectus muscle. It is the form of ventral hernia described as omental which is occasionally the source of error. A case illustrating this came under my care last year; a man 26 years of age, a laborer, was admitted into the Toronto General Hospital, complaining of pain in the epigastrium. He had a small swelling about an inch and a-half in diameter, the centre of which was in the middle line three inches below the zyphi-sternal articulation. The bulk of the tumor could be diminished considerably on manipulation, one could not detect any impulse on coughing. The patient had some digestive trouble, vomiting occasionally after meals and complaining of nausea and some pain in the abdomen; the bowels were constipated. The diagnosis of ventral hernia was made and an operation performed. Immediately beneath the deep fascia was found a soft lobulated mass of fat about the size of a hazel nut, a distinct pedicle from this passed through the linea alba. A ligature was applied at the base of the pedicle and the fat tumor removed; another but smaller piece of fat with similar connections was dealt with in the same manner; deep sutures were introduced and the wound closed with a few superficial stitches. This tumor was situated immediately under the deep fascia and there was no serous sac covering it; there was an excessively thin capsule, from which septa passed between the lobules; the tumor was no doubt connected by its pedicle with the sub-peritoneal layer of fatty tissue and had passed out through the linea alba; it was therefore not omental, but sub-peritoneal fat. The man's digestive derangement was not affected by the operation.

These cases, then, occurring either in connection with the visceral peritoneum—as in the cases referred to of lipoma connected with the colon—or in connection with the parietal peritoneum, as in some cases erroneously described as ventral herniæ, illustrate the fact that lipomata occasionally develop from the sub-peritoneal fat, and we have therefore suggested to us a possible source for the development of certain fatty tumors occurring in

the inguinal region, that group of lipomata which forms the subject of my paper.

My attention was drawn to the subject by the examination of the specimen which I now show you; it was found in an adult male subject in the dissecting room of the University of Toronto and was exhibited to me by a student who took it to be an inguinal hernia. During the dissection of the left spermatic cord, a piece of fat about the size of a walnut was found lying within the coverings of the cord, and in front of the constituents of the cord; this I examined carefully, and on failing to find any peritoneal sac, I investigated further by opening up the abdomen in the middle line and dividing the whole thickness of the wall transversely at the level of the umbilicus. I then examined carefully the inguinal pouches from within, and the structures lying in contact therewith. The omentum was lying free, as were also the intestines, and there was no protrusion whatever of the peritoneum through the internal ring or in its neighborhood. I then carefully dissected off the parietal peritoneum and found that there was no hernial sac engaged in the inguinal canal. Having thus stripped off the peritoneum entirely, the fatty tumor in the inguinal canal was still undisturbed, and I noted the following condition. The fatty tumor protruding at the external ring was attached to a long pedicle which lay in the inguinal canal, the pedicle passed through the entire length of the canal and was continuous with the sub-peritoneal layer of fatty tissue within the abdomen in the region of the internal ring and the deep epigastric artery. It at once occurred to me that the specimen was a valuable one, on account of the possible sources of error in diagnosing such a condition during life.

There are two difficulties which might be encountered in dealing with such a condition during life. 1. The fatty tumor might be mistaken for an omental hernia, and, 2, a true hernia might exist along with the tumor and might be overlooked. The latter difficulty is the more important, as an error in diagnosis might lead to serious consequences. Professor Annandale* records the case of a fatty tumor the size of an orange, which was clearly not omental, occurring in the femoral region; during an operation for its removal the fat was carefully examined and separated, and embed-

* *Edin. Med. Jour.*, March, 1870.

ded in its midst was found a small femoral hernia contained within its peritoneal covering. He records more than one case of a similar character, and speaks of the danger in dealing with such a condition; the possibility that the operator, whilst not recognizing the true condition of affairs, might be tempted to excise the tumor without reducing the hernia, thereby opening up the peritoneal cavity and possibly wounding the gut or omentum.

These cases recorded by Prof. Annandale were in the femoral region, where, in the neighborhood of the crural ring, the sub-peritoneal fat is usually well developed, it might easily occur also in the inguinal region the sub-peritoneal fat in extending downwards in the canal might tend to the protrusion of a peritoneal pouch into which a hernia might descend. Prof. Annandale, however, did not attribute the source of these fatty tumors to the sub-peritoneal fat, there was no proof at the time when his cases were recorded that such lipomata were developed from such a source. The possibility, therefore, of a hernia, accompanying a fatty tumor devoid of serous covering, should always be borne in mind in operating on lipomata in hernial regions. In distinguishing such tumors from omental hernia there is a possible source of error in mistaking the capsule of the lipoma for a serous sac, this is the more likely to occur when, as sometimes happens, the capsule is thickened and resembles to a considerable degree a peritoneal covering. The smooth glistening surface of the peritoneum would appear on opening a true hernial sac, and then again the capsule of a fatty tumor has, as a rule, septa which pass in between the lobules. By keeping these points in view one can generally distinguish between a tumor capsule and a peritoneal sac.

The fact that such tumors as I have described originate in the sub-peritoneal fat is not generally recognized. Sir James Paget suggested this view and it is put forward by Jonathan Hutchison, Junior,* in a paper read before the Pathological Society of London. I cannot, however, find any reference to it in the English text books on surgery which I have consulted. The tumor which I have dissected and described proves conclusively the possibility of the occurrence of such tumors and their source; and the case of ventral so-called hernia which I have narrated suggests that they

may be looked for in other hernial regions as well as in the inguinal canal.

I need only but refer to the other fatty tumors which are found in the inguinal region. Omental herniæ are common. Last year I narrated before the Toronto Medical Society the history of a case of imperfect transition of the testis operated on by Dr. Cameron. In that patient we found an omental hernia lying above the testicle in its own peritoneal sac. The omental mass was the size of a duck's egg, and was almost exclusively confined to the inguinal canal, the walls of which were expanded over it. Then again there are occasionally, but rarely found, tumors in the region of the canal, although not within the coverings of the cord, developed from the subcutaneous fat and extending down towards the scrotum. An interesting case of this kind is reported by Henry Gray,* in which the fatty growth continued downwards and was continuous with the dartos tissue of the scrotum. These tumors, however, lie outside the inguinal canal, and therefore can hardly be included in the group indicated by the title of my paper.

It is an accepted fact that fatty tumors are only found in situations where fat is normally developed in the body, and that they originate from the pre-existing adipose tissue. The possible sources of such growths occurring in the inguinal region, therefore, are first, those found within the coverings of the cord, their source, being either (a) omental or (b) from subserous fat; and secondly, those lying outside the coverings of the cord developed from the subcutaneous fatty tissue.

Reports of Societies.

GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

APRIL MEETING.

The President, Dr. Henry M. Wilson, in the chair.

Dr. Wm. P. Chunn related a case of ascites, which he treated by tapping and permanent drainage with apparently good results.

Dr. B. B. Browne, more operated than a year ago upon a woman with ascites, who also had an

**Path. Soc. Trans.*, Vol. XXXVII, p. 451.

**Path. Soc. Trans.*, Vol. V., p. 230.

abdominal tumor which proved to be papillomatous.

There has been no return of either the dropsy or the papillomatous growth. He referred to the many cases of laparotomy and washing out the abdominal cavity.

Dr. Geo. W. Miltenberger could not see why any malignant tumor should not be able by irritation of the serous membrane to cause ascites. We often see ascites without any definable cause, and when a growth did exist it seemed a very good reason for the presence of the fluid. He referred to the case of a colored woman operated upon by Dr. Neale.

Dr. L. E. Neale said that in the case of the colored woman referred to, there was no assignable cause for the ascites except the presence of a subserous uterine foetus myomata; at the operation he removed the uterine appendages. The growth remained, but there was no return of the ascites. There was also a complete procedentia, but after the operation he was enabled to keep the uterus in place with a soft rubber ring. The tumor gradually diminished and ultimately disappeared.

Is the exposure and irritation of the serous membrane, during the operation, a sufficient explanation of such an alteration in its function when the apparent cause of the ascitic extension remains?

He thought the question eminently important and practical in its bearings, and that it required further elucidation.

Dr. Wilmer Brinton remarked that in a case of cirrhosis of the liver in a male patient, tapping for the ascites had been followed by a permanent opening which persisted until the patient's death one month afterwards.

Dr. J. Whitridge Williams, in referring to Dr. Moseby's remarks said that the ascites accompanying papillomatous growths was considered to be due in great part to direct exudation from the vessels of the growth—he also referred to tubercular peritonitis.

Dr. B. B. Browne exhibited a small tumor about the size of a large hickory nut, and apparently a fibroid which he had removed from a point a little to one side of the median line, and between the clitoris and urethra. It pressed on the urethra interfering with micturation. The growth was easily shelled out, and the patient did perfectly

well. It was the first growth of the sort that he had seen in that locality.

Dr. Neale related a case of imperforate rectum in a white male child naturally borne at full term of healthy parents. The child was puny, weighing only $5\frac{3}{4}$ pounds at birth, and one inch within the anus the rectum was imperforate. Dr. T. Hanny operated upon the child when it was two and a half days old, very feeble and partly cyanosed. No anesthetic was used, anus was cut through, the perineal structures laid open, the coccyx removed, the rectum opened through its posterior wall just above the imperforate part, and its mucous membrane stitched to the skin just behind the original anal aperture. The stitches sloughed out and the large wound healed slowly by granulation. A copious discharge of flatus and meconium occurred during the operation, and the tympanitic abdomen disappeared.

Profound shock and collapse followed the operation, the child lying motionless, the feet and lower limbs cyanosed, the face and head less so—jaw dropped, mouth opened, eyes closed, lids blue, surface temperature but little if at all lowered. No cry. The features were frequently pinched or wrinkled from pain, becoming more or less blue at irregular intervals.

In this condition the child would make no effort at suction, but would swallow two teaspoonfuls at a time of milk and brandy when poured into its mouth, rarely refusing to swallow and never vomiting the food and stimulus which were given freely and frequently. For nearly two days and a half did it remain in this state—partially rousing during the administration of food or other disturbance, and again relapsing. Even after this period, when the first decided improvement occurred, the child would frequently relapse and remain in this condition for hours at a time. The first two weeks of its life were passed in this manner. The digestive and urinary apparatus functioned normally.

From the tenth to the fourteenth day these attacks gradually diminished and ultimately disappeared. The child is nearly two months old, but very feeble, and weighs only $5\frac{1}{4}$ pounds. It has been reared chiefly on condensed milk. The dense cicatrice just about the seat of the old imperforation has to be dilated daily with the finger; another operation will be necessary. No diagnosis of abnormality in vascular system could be made.

Dr. Brinton mentioned a case of a child which lived nine or ten days with an open ductus arteriosus.

Dr. Miltenberger said that in Dr Neale's case the sphincter and anus were perfect. On introducing his finger to the end of the cul de sac he felt what appeared to him the end of the coecyx.

He thought that no cardiac trouble could account for the symptoms in the case. The cyanosis would not clear up entirely and then recur. He did not consider the condition one of collapse. There was no feebleness of pulse or coldness of surface. The child would lie in an apparently comatose condition, with no evidence of sensation, and then recover. The first attack followed immediately the operation, and evidently from shock; but after two or three days it could not be attributed to this cause. There was no chill or febrile condition.

After the child had commenced taking food he used quinine by inunction and also small doses of dialyzed iron, and as he believes with benefit from the latter.

He was inclined to account for the condition in this way:—A very feeble child had food forced upon it for eight or ten hours, and when it had taken in all it could it apparently fell into a condition similar to that of hibernating animals, and when the supply of food was exhausted it would recover and take more nourishment. This condition entirely disappeared after the first two weeks.

THE ONTARIO MEDICAL ASSOCIATION.

This Association met on the morning of June 3rd, Dr. Moorhouse, of London, in the chair. The minutes of last meeting were read and approved; and the President called upon delegates from the United States to seats upon the platform which call was responded to by Dr. Senn, of Chicago; Dr. Carman, of Buffalo; Dr. Meikle, of Buffalo; Dr Howard Kelly, of Baltimore; Dr. Mynter, of Buffalo. After a few remarks by these gentlemen, Dr. Teskey was called upon to read the address on Surgery. The subject of the address was "Carcinoma." Dr. Teskey dwelt upon irritation as a cause of carcinoma believing that in many cases inflammatory products, at first simple in character, by prolonged irritation took on malignant

action, and adjacent lymphatic glands became involved, and the tumor ultimately passing in character into a malignant one. He believed it quite possible for the changed character which the epithelial cells possess in epithelioma to be induced by simple irritation, and cited examinations of doubtful growths wherein many cells possessed malignant characters, whilst others were perfectly normal. He also spoke of the tendency in some cases to natural cure by sloughing, and cited a case of cancer of the breast where a suppurative process appeared to arrest the growth and development of a tumor, which, to all appearances, was cancerous. He had had the same under observation for seven years, and so far there was no evidence of the return of the malignant action which at first characterized the growth.

Dr. Senn, of Chicago, took part in the discussion, and dwelt upon the theory of Conheim, that embryonic elements remaining among the tissues accounted for the origin of the carcinoma. For himself he did not believe that irritation alone could cause carcinoma, and drew attention to the a change to the character of epithelium.

liability to such growth at seats where there was

Dr. Groves, Fergus, followed; he also doubted the influence of irritation causing such growth, and thought pigmentation and similar changes in cell elements might operate as a predisposing cause, and drew attention to the apparent heredity of carcinoma, and its particular liability to appear at certain periods of life when irritation generally was not particularly increased.

Dr. Teskey replied.

Dr. Oldright next had a paper on Dr. Senn's method of decalcified bone-filling, with the exhibition of a case in which the treatment had been tried. (This paper will appear in a later issue.)

The Association then divided into sections.

Wednesday Afternoon.

The Association met again in general session at 2.30 p.m. The President in the chair.

Vice-Presidents Dr. J. H. Richardson and Dr. J. A. Temple were invited to take their seats upon the platform.

The President read his annual address, in the course of which he gave a *resumé* of the History of Medicine, from the time of Hippocrates to the present, touching upon the salient features of its different epochs. In his closing remarks, the Pre-

sident referred to the high standard of medical education in Ontario, which he deemed was chiefly due to the wise measures taken by the Medical Council, to whom all credit is due.

He also referred to the advance made by the Ontario Medical Library Association, and prophesied that within a very short time its shelves would contain all the books of reference of use to the profession.

The question of Club Practice was touched upon in very condemnatory terms, and the President expressed the hope that in time the sentiments of the profession against this species of practice would grow strong enough to stamp it out entirely. Any general practitioner who still persisted should be held responsible to this Association.

It was also a matter of regret that so many practitioners persisted in advertising their specialties. This was a direct violation of the Code of Ethics.

One more very important matter was referred to, namely, the establishment of a Medical Defence Union for the members of the Association. Such a Union would do much to prevent suits for malpractice, and would be a great assistance to the poorer members of the profession, against whom these suits were generally brought. Care would require, however, to be taken to guard such a Union from any carelessness on the part of its members. The opinions expressed by the President called forth great applause from the members of the Association.

Dr. Howard Kelly, of Johns Hopkins University, Baltimore, was introduced to the President by Dr. A. A. McDonald, of Toronto, and was invited to take a seat upon the platform.

Dr. N. Senn read a paper upon the "Surgical Treatment of Intussusception." This paper was to have been illustrated by operations upon the intestines, but owing to the absence of the necessary apparatus, the illustration of "Intestinal Anastomoses" had to be deferred to the evening session.

The Association then adjourned, and resumed business in sections.

'SURGICAL SECTION.

The Surgical Section met in the main hall. Dr. F. LeM. Grasset, Toronto, was elected chairman, and Dr. A. Primrose, secretary.

Dr. A. Mynter, of Buffalo, was permitted to read his paper at this hour, on account of his necessary return to Buffalo in the evening. His paper was entitled, "Is early Resection or Conservative Treatment advisable in Coxitis?" Before this paper was discussed, Dr. Bingham, of Toronto, was asked to read his paper on "The Surgery of Tuberculosis."

Dr. Mynter opened the discussion on the paper, followed by Dr. McFarlane, Toronto, Dr. B. E.

McKenzie, Toronto, Dr. Oldright, Toronto. Dr. Bingham replied.

The next paper read was short notes on "Injuries to the Skull and Epithelioma of the Larynx," by Dr. Burt, of Paris. There was no discussion.

Dr. T. K. Holmes, Chatham, followed with a paper entitled, "Appendicitis," reports of fourteen cases, showing the result of surgical as compared with medical treatment. The section then adjourned.

MEDICAL SECTION.

4.45 p.m.

Dr. J. E. Eakins, of Belleville, was elected chairman, and Dr. W. B. Thistle, secretary, of the Medical Section, which was convened in the Council chamber, second floor.

The section was opened by a paper from Dr. J. E. Graham, on the "Diagnosis of Typhoid Fever." The paper was discussed by Dr. Sheard, Toronto, and Dr. McPhedran, Toronto. Dr. Graham replied.

The second paper read was one by Dr. H. Arnott, of London, "Is Alcohol a Stimulant?" In conclusion he submitted a resolution concerning the use of alcohol by the profession. Dr. J. S. King was of the opinion that the resolution should include opium. Dr. J. E. Graham pointed out that the resolution was out of order. Dr. Arnott replied.

Dr. T. Millman, Toronto, then read a paper entitled "Epileptic Insanity." The paper was discussed by Dr. Arnott and Dr. Rice. It being 6 o'clock, the section then adjourned.

WEDNESDAY EVENING, GENERAL SESSION.

The evening session was opened at 8.30 p.m., the President in the chair.

Dr. M. Sullivan expressed his regret that he was obliged to leave for Ottawa at once, and was therefore unable to take part in the discussion of Mr. Senn's paper as he had promised. Before leaving he paid a high compliment to Dr. Senn for his service to the Science of Surgery.

Dr. Senn demonstrated his method of bringing about "Intestinal Anastomoses." A great interest was shown by the members in the different steps of the operation.

The discussion in Medicine was then opened by a paper entitled "The Cardiac Phenomena of Rheumatism," by Dr. A. McPhedran, of Toronto.

In the absence of Dr. Henderson, of Kingston, and Dr. Gilles, of Teeswater, the discussion was opened by Dr. H. A. McCallum, of London, followed by Dr. Chas. Sheard, Toronto, Dr. McPhedran closed the discussion.

The ballots were here distributed for the Nominating Committee, and the members were asked to record their vote for 12 members of this Committee, there being 174 members registered at the time of taking the vote, Dr. J. D. Thorburn and

Dr. C. A. Hodgetts were appointed scrutineers, to count the ballots.

The discussion in Therapeutics was postponed owing to the absence of Dr. Saunders, of Kingston, Chairman of the special Committee.

The report of the Committee on Ethics was read by Dr. Tucker, of Orono, and was as follows: As the outcome of an investigation just completed, we recommend the addition to the Code of Ethics adopted by this Association of the following clause to be known as Section 10 of Article V.

1. No Physician or Surgeon shall perform a post-mortem on the patients of any other Physician or Surgeon, without making a reasonable effort to have the attending Physician or Surgeon, or the Physician or Surgeon whose professional reputation is likely to be influenced by the post-mortem examination, or his chosen representative present, and further if the presence of such Physician or Surgeon or his chosen representative be objected to by the friends of the deceased, the Physician or Surgeon requested to make the post-mortem shall refuse to make it, unless instructed to do so by a Coroner acting as such.

2 As the result of complaints made to this Committee regarding unprofessional conduct by the violation of Par. 3 of Sect. 1 of Article II. of the Code Ethics, relating to certain forms of advertisement, we recommend that the General Secretary be instructed to inform the offending members by letter that they are violating the Code of Ethics governing this body, to which their names are subject, and your Committee will recommend the erasure of their names from the roll of membership of this Association at its next annual meeting unless the offending be at once discontinued. Their reinstatement to be governed by 1 Par. 2 of the Constitution.

3. Regarding the circular issued by a member of this Association and brought before this Committee, your Committee recommend that a written apology be demanded by this Association through its General Secretary for such a flagrant violation of our Code of Ethics, in default of which his name be erased from the roll of membership. Reinstatement to be governed by Article XII of the Constitution.

The adoption of this report was moved by Dr. Tucker, of Orono, seconded by Dr. Lundy, of Preston.

The report of this Committee was discussed by Dr. Ferguson, Toronto, who desired to introduce a motion condemnatory of Club Practice, and to have the report thus amended.

Dr. Ferguson's motion was ruled out of order.

Dr. Sheard, Dr. Burnham, Dr. Oldright, and Dr. Powell, Toronto, spoke in condemnatory terms of Club Practice. The report was unanimously carried.

Thursday morning, June 4th.

The Association met in sections at 9.30 a.m.

SURGICAL SECTION.

Dr. Primrose, of Toronto, opened this section with a paper entitled "Fatty Tumors in the Inguinal Canal."

Dr. Grasett followed with a paper entitled "Concerning Lithotomy." The paper was discussed by Dr. Holmes, Chatham, and Dr. Eccles, London.

The next paper read was by Dr. J. F. W. Ross, Toronto, entitled "Exploration of the Female Bladder." The paper was discussed by Dr. Grasett, Dr. Kelly, Dr. Dame, Dr. Ross, Dr. McFarlane, and Dr. Teskey, Toronto.

Owing to the absence of the other gentlemen appointed to read papers before the section at this hour, the section adjourned for ten minutes and resumed with Dr. James Ross in the chair, in the absence of Dr. Grasett, at the Committee on Nominations.

Dr. Price Brown read a paper on "Deviations of the Nasal Septum." There was no discussion.

Dr. B. E. McKenzie, Toronto, exhibited four cases illustrating the "Management of Talipes." The section then adjourned, it being 12 o'clock.

The report of the scrutineers appointed to count the ballots for the Committee on Nominations, was read by the Secretary.

The following gentlemen were declared elected: Dr. McPhedran, Chairman, Dr. Cameron, Dr. Graham, Toronto, Dr. Burt, Paris, Dr. Holmes, Chatham, Drs. Sheard, Powell, A. H. Wright, and Reeve, Toronto, Dr. Eccles, London, Dr. Arnott, London, Dr. Grasett, Toronto.

The Committee to meet in Committee room "A," at 11 o'clock.

MEDICAL SECTION.

Section was called to order at 9.30 a.m.

In the absence of Dr. Eakins, Dr. McPhedran moved that Dr. Arnott, of London, take the chair.

Dr. Bruce Smith, was called upon to read the first paper, "A Narrow Prepuce and Preputial Adhesions in Childhood." The discussion was opened by Dr. Howitt, of Guelph, followed by Dr. Arnott, of London, and Dr. McWilliams. Dr. Bruce Smith replied.

Dr. Gardiner followed with a paper on "Pelvic Cellulitis." The paper was discussed by Dr. Rice, of Woodstock, Dr. Sheard, and Dr. Wright, Toronto. Dr. Gardiner replied.

Dr. A. B. Osborne, Hamilton, read a paper on "Pathological Weeping." The paper was discussed by Dr. Birkett, of Montreal, Dr. Trow, of Toronto, Dr. Hamilton, Toronto, Dr. Thorburn, Toronto. Dr. Osborne replied.

Dr. J. McWilliams, of Thamesford, read reports for five cases of "Phlegmasin Dolens," with treatment.

Dr. Adam Wright, followed this with a paper on "Phlegmasia Dolens." The discussion was opened by Dr. Barrick, of Toronto, followed by Dr. Cronyn, of Buffalo, Dr. McWilliams, of Thamesford, and Dr. Rice, of Woodstock. Dr. Wright closed the discussion.

The report of the scrutineers for the Nomination Committee was here read by the Secretary, and the Committee requested to meet at 11 o'clock. The section then adjourned.

Thursday Afternoon, 2.30 p.m.

The Association convened in general session.

Dr. Cronyn, of Buffalo, and Dr. H. S. Birkett, Secretary of the Canada Medical Association, were here introduced by the President, and requested to take their seats upon the platform.

The report of the Nomination Committee was by Dr. McPhedran, Chairman, as follows:

President.—Dr. R. A. Reeve, Toronto.

Vice-Presidents.—Dr. F. LeM. Grasett, Toronto; Dr. A. Groves, Fergus; Dr. H. J. Saunders, Kingston; Dr. G. S. McKeough, Chatham.

General Secretary.—Dr. D. J. Gibb Wishart, Toronto.

Assistant Secretary.—Dr. F. P. Cowan, Toronto.

Treasurer.—Dr. E. J. Barrick, Toronto.

ADDITIONS TO STANDING COMMITTEES.

Credentials.—Dr. Duncan, Chatham, and Dr. Eakins, Belleville.

Public Health.—Dr. W. A. Ross, Barrie; Dr. Trimble, Queenston.

Legislation.—Dr. McKay, Ingersoll; Dr. Gilmore, West Toronto Junction.

Publication.—Dr. H. J. Saunders, Kingston; Dr. W. H. B. Aikins, Toronto.

By-Laws.—Dr. J. E. Graham, Toronto; Dr. H. A. McCallum, London.

Ethics.—Dr. Moorhouse, London; Dr. H. P. Wright, Ottawa.

The President expressed to the Association the regrets of Dr. Joseph Workman, Toronto, first President of the Association, that ill health prevented his attendance at the meeting. He assured the Association of his continued interest in its proceedings and advancement, and expressed the hope that the present meeting would be in every way a success.

A telegram was read from Dr. G. Roddick, of Montreal, regretting that the sudden and dangerous illness of Dr. Rogers prevented his attendance at the meeting.

Dr. Arnott, of London, asked the permission of the Association to move the following resolution: "That in view of the great amount of misery, degradation and disease that has come upon our race from the use of alcohol, it is the opinion of this Association that it should be prescribed as seldom as possible and with a due sense of responsibility."

Dr. Oldright, Toronto, was willing to second the motion provided the words "compatible with the interests of the patients," were inserted after the words "as possible." Dr. Arnott agreed to the change.

Dr. Temple, Toronto, expressed himself as opposed to the proposed resolution. He deemed that the resolution implied a slur on the medical profession, as it was the practice to exercise as much care in the prescription of alcohol as that of opium.

It was moved by Dr. Sheard, seconded by Dr. Eccles, that the resolution be tabled. Carried.

Dr. Eccles, of London, opened the discussion in Obstetrics and Gynaecology by reading a paper entitled "Myoma of the Uterus."

The discussion on the paper was opened by Dr. A. MacDonald, of Toronto, Dr. J. H. Matheson, St. Marys, one of the members of this committee not being present. Dr. Eccles replied briefly.

Dr. Kelly, Baltimore, Md., read a paper entitled "Injuries of the Vaginal Outlet occasioned by Parturition," which he illustrated profusely by bromide plates and chalk drawings.

His paper was discussed by Dr. J. A. Temple, Toronto. Dr. Kelly replied briefly.

Dr. A. McPhedran, Chairman of the Committee on Nominations, moved the adoption of the report read previously in the afternoon. The motion was seconded by Dr. Sheard, Toronto. Motion was carried.

The Secretary read a communication from the Secretary of the Canada Medical Association, requesting the appointment of four delegates from this Association to the meeting of the Canada Medical Association in Montreal in September, in accordance with the terms of arrangement made by a joint Committee from the Ontario Medical Association and the Canada Medical Association last September.

It was moved by Dr. Grasett, Toronto, seconded by Dr. Sheard, Toronto, that the President be authorized to appoint four delegates to the Canada Medical Association. Carried.

SURGICAL SECTION.

The section was called to order at 4.45 p.m.

The following papers were discussed. Dr. A. E. Malloch, of Hamilton, reported a case of "Excision of the Shoulder and Elbow Joints of the same Arm for Traumatism," and exhibited the patient.

Dr. G. A. Peters, Toronto, followed with a paper on "Acute Osteomyelitis," and exhibited the cultures. Discussion was opened by Dr. N. A. Powell, Toronto. Dr. Peters closed the discussion.

MEDICAL SECTION.

The section was called to order at 4.45 p.m.

Dr. H. A. McCallum, London, was called upon

to read his paper called, "Some Points in Pathology in Kidney Diseases." The paper was discussed by Dr. A. McPhedran, and Dr. C. Sheard, Toronto. Dr. McCallum replied. The section then adjourned.

THURSDAY EVENING, GENERAL SESSION.

The Association was called to order at 8.30 p.m. The President, Dr. W. H. Moorhouse, in the chair.

The President asked the permission of the Association to change the order of business, and called upon Dr. A. Stowe Gullen, to read a paper entitled, "Medicine from a Sociological View Point." The paper was discussed by Dr. Sheard.

The discussion in Otolgy was opened with a paper from Dr. R. A. Reeve, entitled, "Points of General interest in Otolgy." The discussion was opened by Dr. A. B. Osborne, of Hamilton, followed by Dr. Moorhouse, of London, and Dr. Birkett, of Montreal. Dr. Reeve replied.

It was moved by Dr. MacDonald, seconded by Dr. Wishart, that the papers of Dr. Saunders, of Kingston, Dr. Cauldwell, of Peterboro, Dr. Greig, of Toronto, Dr. Campbell, of Seaforth, and Dr. King, Toronto, be taken as read. Carried.

Dr. G. S. Ryerson, Toronto, then read a few extracts from his paper entitled, "Bearings of Color Blindness," and in conclusion, seconded by Dr. J. E. Graham, presented the following resolution:

"Whereas the attention of the Ontario Medical Association has been called to the methods employed in examination for color blindness on Railroads, and in the Marine Service in Canada,

And whereas it is believed that the said methods are imperfect, and do not absolutely eliminate the color blind from among Railroad or Marine employees, and that serious danger arises to the travelling public from this cause,

Resolved—That the attention of the Hon. Minister of Railroads and Canals, and of the Hon. Minister of Marine and Fisheries, and the Presidents of the G. T. R. and C. P. R. and other railroads, be drawn to this fact, and that they be earnestly desired to give this important matter their most serious consideration.

And resolved, that the Secretary transmit a copy of this resolution to the parties interested." This resolution was adopted.

Dr. Britton's paper on "Hæmaturia" was taken as read.

Dr. Ferguson, M. P., Welland, was asked to take a seat upon the platform.

The Association proceeded with the next order of business, the reports of Committees.

The report of the Committee on Legislation was read by Dr. W. B. Geikie, Toronto.

Your Committee beg leave to report that the following bill amending the Medical Act, was adopted at the last session of the Legislature. Beyond this, your Committee is not aware of any other legislation affecting the Province. A copy

of the Bill No. 175, 1891, accompanied the report. The adoption of the report was seconded by Dr. Wishart. Carried.

Dr. Spencer, Chairman of the Committee on Credentials, presented the final report of that Committee; 193 ordinary members, and 7 guests were registered as attending this meeting.

There were 28 applications for membership, all of which were accepted. The adoption of this report was seconded by Dr. Sheard. Carried.

The report of the Committee of Public Health. Owing to the absence of the Chairman on Public Health, Dr. Kitchen, of St. George, the report was taken as read.

The Committee on Publication reported through Dr. Primrose, all the papers read at the meeting of the Association to be divided between the two Toronto journals. The report was adopted.

Dr. Price Brown, Toronto, moved as follows: That the following amendments to the By-laws as recommended by last year's Committee on By-law, be adopted.

1. That the Advisory Committee be added to the list of standing Committees.

2. That Committees upon the following subjects: Surgery, Pathology, Medicine and Physiology, Materia Medica, Therapeutics, Obstetrics and Gynæcology, Ophthalmology, Otolgy, be added to the list of temporary Committees.

3. That the Code of Ethics of the Ontario Medical Association be the same as that of the Canada Medical Association as recommended by the former in 1889—Constitution Art. X.

This report was seconded by Dr. Wishart, on the condition that clause No. 2 be omitted. Resolution was adopted and the change in the By-laws ordered.

The Committee on Business presented their final report through Dr. MacDonald, Chairman.

The report of the Committee on Necrology was read by Dr. Lett, of Guelph, as follows: During the year three members of the Association have been called away by death. Dr. C. Irwin, of Kingston, died 13th of August, 1890, aged 48 years. The deceased member was a member of the Ontario Medical Council from 1875 to 1885, Vice-President of the Ontario Medical Association, 1881, Professor in Medical Jurisprudence Royal College of Physicians and Surgeons, Kingston, 1882 to 1888, Professor in Clinical Medicine, 1889 to the time of his death. Dr. Irwin's kindly and sympathetic nature won for him the high esteem and good-will not only of his *confretrés* but also that of the profession in general, and secured for himself a large practice.

Dr. J. B. Tweedale, of St. Thomas, who graduated in Victoria University in 1862, passed away during the year.

Dr. John Madill died at Alliston on the 2nd February, 1891, one month after the death of his

wife. He was a graduate of McGill University, 1867.

The adoption of this report was seconded by Dr. R. A. Reeve, and carried.

The Committee on Audit reported through the Secretary that the books of the Treasurer had been duly audited and found correct.

The Committee on Coroner's Inquests reported progress and asked leave to sit again.

The report of the Treasurer was read by Dr. E. J. Barrick, which was adopted and carried.

A vote of thanks to the Ontario Medical Council for the accommodation so freely given to the Association for its different meetings, was moved by Dr. Powell, seconded by Dr. Wishart. Carried.

The President then declared the meeting adjourned.

Selected Articles.

OBSERVATIONS UPON THE TREATMENT OF CERTAIN CASES OF FATTY HEART.

The following observations based upon the record of a case of extreme interest that occurred in my practice during the summer of last year, are intended to apply to those cases of fatty heart that are associated with obesity, where the symptoms of cardiac embarrassment are due rather to an overloading of the heart muscle, both superficially and between its fibre, with a deposit of adipose tissue, than to a true fatty degeneration of the muscular fibres. I am anxious to define this clearly at the outset, since I do not wish it to be supposed that the treatment I am about to advocate should be applied indiscriminately to all cases where the diagnosis of "fatty heart" has been made. We must distinguish as far as possible between a mere fatty deposition and infiltration, although we know that the former condition probably can never exist to any considerable extent without the latter resulting to some degree as an effect. But treatment that may be successfully pursued in cases where the symptoms are dependent upon fat accumulation might be followed by baneful, if not positively fatal, results in other cases where degeneration is at the root of the disease.

With this definition as to the nature of the class of cases to which the remarks that follow are intended to apply, I will now proceed to a brief narration of the case, the extreme interest of which has prompted me to bring its record before you this evening.

The patient, a gentleman, *æt.* 50, in very comfortable circumstances, I first saw in April, 1889, but at this time there was nothing noteworthy in his symptoms. On May 8th, 1890, immediately

after his return from the Isle of Wight, where he had spent the winter, he called on me, complaining of attacks of breathlessness, accompanied with difficulty in walking, occurring once every three or four weeks for the previous six months, usually in the afternoon or evening, and lasting from four to six hours. His height is 5 feet 7½ inches, and at this period he weighed 14 stone 5 lbs., while his girth at the umbilicus was 42 inches. For several years he had led an inactive life, with considerable self-indulgence in alcohol, particularly in the form of malt liquors. He had had no previous illness bearing upon his present condition, excepting an attack of influenza during the epidemic in February, which appears to have left him in a very debilitated state.

Physical examination on May 8th revealed as follows: Lungs healthy; heart's apex beat scarcely palpable, but normal in position. Right border indistinctly made out through the massive chest wall to be about one inch to the right of the sternum. First sound muffled and indistinct at apex, no murmurs anywhere. Pulse 72, feeble. Digestive system: appetite poor, pain at pit of stomach half-an-hour after food, flatulence, tendency to diarrhoea and morning sickness. Urine, pale, clear, acid, *sp. gr.* 1008, no albumen or sugar.

On June 6th I was called to see him in one of the above-mentioned attacks of breathlessness. I found him lying upon his back on a sofa, face more or less livid, and drawing his breath with very considerable difficulty. Pulse regular in force and rhythm, but more feeble than usual. A hypodermic injection of ether improved his condition temporarily, though the attack did not quite pass off for an hour or more. I now prescribed for him half-a-grain digitalis, with one-thirtieth grain arsenious acid in a pill, and a mixture containing liquor strychniæ ℥ v., and acid nitromur dil ℥ xv., in the dose to be taken after food, enjoining at the same time as much rest as possible, and a light nutritious diet.

Similar attacks occurred on the 7th and 8th of June, and indeed almost daily till the 24th, when he very reluctantly consented to keep his bed entirely. After this he had no attack until July 3rd, when he exerted himself more than he should. The urine at this time having become diminished in quantity the digitalis was stopped. I may here state that repeated examination of the urine never at any time revealed the presence of albumen.

On July 11th I found my patient looking decidedly ill. His temperature was 103°, pulse 96, full and bounding. He complained of feeling sick and had vomited after attempting to take some tea. He also complained of slight pain on pressure at the pit of the stomach. His liver was enlarged, reaching 2½ inches below the costal mar-

gin, its edge feeling resistant and smooth, but tender to pressure. Tongue rather brown, but moist, no icterus anywhere. Ordered hot poultices over liver, ice to suck, and milk and seltzer water.

July 12th.—Condition much the same. Temperature 103°. Sickness had ceased. Bowels moved several times; stools watery, small in quantity and very dark.

July 13th, 14th, 15th and 16th.—The temperature continued about 100° to 100.8°. Bowels moved several times a day, stools of same character as before. The liver remained about the same size, although the tenderness over it decreased. On the 16th I ordered a powder of calomel gr. v. with pulv. ipecac. co. gr. x. In the evening of the same day the temperature had come down to 99.8° and the vertical liver dulness had decreased one inch. The same powder was repeated on the 18th, 20th and 22nd, producing a most satisfactory amelioration of all the symptoms, and on the 25th the liver could only just be felt below the costal margin. He was allowed to go out on July 26th for the first time, when his weight was ascertained to be 11 stone 7 lbs., and his girth was 35 inches; that is to say, since May 8th, he had lost in weight 3 stone all but 2 lbs., and in girth 7 inches.

It is to be noted that during the whole time of the liver disturbance, which necessitated absolute rest in bed, there were no attacks of dyspnoea. The nature of the illness at this time must, I think, be regarded as an attack of hepatic congestion with febrile symptoms. Whatever its cause might be it appeared to me, as I told my patient at the time, that the condition of fever through which he had passed had been for him by no means an unmixed evil, since it had proved a very rapid and effectual means of getting rid of a very considerable amount of fatty tissue that had previously embarrassed him, and had without doubt caused the attacks of breathlessness from which he suffered. The febrile furnace once set going had burnt up so much superfluous fat that my patient now appeared a comparatively lean man, with a heart freed from the superabundant deposit upon its surface and between its fibres, that had previously caused its embarrassed action.

I now argued to myself that if I could succeed in preventing the re-accumulation of fat I could almost positively promise my patient an absolute cure. With this object in view I determined to exercise a strict supervision over his dietary, and the plan that I adopted was that recommended by Oertel in his "Therapeutics of Circulatory Derangements," diminishing the amount of fluids, fatty foods, and carbo-hydrates to a minimum, while allowing a liberal supply of nitrogenous food. I need not enter into the details of his dietary during convalescence, further than to say

that by gradual modifications I worked him up to the following, which I prescribed on July 28th, and to which he has rigidly adhered ever since.

Breakfast.—One small cup of tea with milk, but without sugar; bread, 2½ ounces; an egg beaten up in the tea, and some lean ham or a lean chop.

Dinner.—A teacupful of clear soup. Of roast or boiled meat, game or fowl, without fat, seven ounces. White fish, green vegetables, no potatoes, carrots, turnips, parsnips, beetroot or artichokes. Bread, three ounces; custard pudding or jelly, stewed or raw fruits, with very little sugar. As beverage two-thirds of a tumblerful of water, or aerated water, either alone or with 1 to 1½ tablespoonfuls of old whisky.

Tea.—One small cupful, with an egg beaten up in it. Bread, 1½ ounces.

Supper.—White fish, game or poultry, with salad or fruit in small quantity; a little cheese; a little whisky and water as at dinner, or a little dry light wine, hock or chablis.

Such was the dietary. In addition, as his strength improved, I advised him to take as much physical exercise in the way of walking as he could, and after a few preliminary turns of a mile or so, on August 1st he managed five miles in the morning, and took a drive in the afternoon, without experiencing any dyspnoea, and with no discomfort beyond feeling a little tired. On August 22nd, when I last saw him, his condition was as follows: Weight, 11 stone 10 lbs.; girth at umbilicus, 36½ inches; appetite excellent, but he keeps strictly to the dietary ordered; heart normal in position and extent, first sound at apex much clearer and more distinct; liver also normal. On September 22nd, writing from the Isle of Wight, where he still remains, he reported, "I am now enabled to walk up hills without stopping, and can also walk seven miles a day on an average. I have had no attack of shortness of breath."

Again, on January 5th, 1891, he wrote: "I am pleased to say that I am well, and can comfortably walk 10 miles without any distressing sensations. I am now more reduced than ever round my waist, it being only 35½ inches, and my weight only 11 stone 10 lbs.

Now, from a consideration of this case one deduction appears to me fully justified, namely, that the disappearance of the cardiac symptoms must have been brought about by the destruction and removal from the body of the superincumbent fat; and, provided one had the power of successfully effecting such fat reduction, there appears to me no reason why all such similar cases should not result in an equally satisfactory issue. Fortunately for my patient he had the good luck to pass through a week of febrile condition, during which his superfluous adipose tissue was consumed. Believing that his pyrexia was not indicative of any particular danger, and realizing the good that

it would otherwise effect, I made no effort to attain its reduction by antipyretic measures.

Recognizing, therefore, the fact that in such cases a cure may be effected provided one can successfully accomplish the oxidation and removal of the fat, it remains for us to consider how this may be best accomplished. We have at present no means at our command by which we can at will produce a given rise of temperature, which shall be absolutely under our control, and by which the necessary fat combustion shall be brought about. We have at our disposal, however, a method by which, though the process be a slower and more gradual one, the same end may be obtained.

There are three objects towards which our treatment must be directed, viz.:-

Firstly. To get rid of the fat already superabundantly accumulated in the tissues.

Secondly. To prevent its further deposition.

Thirdly. To improve the efficiency of the heart muscle.

These indications are accordingly to be met in the following manner :-

Firstly. By a systematic course of well-regulated exercise, which by increasing the process of oxidation shall necessitate an increased consumption of stored-up fat, and its consequent removal.

Secondly. By prescribing a dietary which shall contain a minimum of fat forming articles, and in which the amount of fluid ingested is restricted to the smallest quantity.

The third indication is met in attending to the other two, but some further assistance may be given in the careful exhibition of such heart tonics as strychnia, digitalis, and strophanthus.

Time will not permit me now to enter into the details of the above proceedings, although a few words in explanation and amplification are necessary.

Regarding the exercise, the form advocated by Oertel is the systematic practice of long walks, especially in mountainous districts, the effects of which may be briefly summarized as follows :-

1. The process of tissue oxidation is increased, and consequently accumulated fat is consumed.

2. The increased demands made upon the heart's activity, as shown in the increased number and force of its contractions, has the same effect in improving the tone and contractile power of the organ that the practice of ordinary gymnastic exercises has upon the development of voluntary muscular power.

3. The increase in the loss of water from the body, due to increased perspiration and loss through the lungs, tends to an improvement in the quality of the blood, both by diminishing its volume, and increasing its concentration. Proportionately to its bulk, it is easy to understand

that its oxygen-carrying power is likewise increased.

Regarding the dietary, in the first place it stands to reason that only the smallest quantities of fat-forming elements (fatty foods and carbohydrates) must be permitted. If under these circumstances, owing to increased muscular activity, the combustion of non-nitrogenous elements in the body exceeds the amount supplied in the form of fat and carbohydrates in the food, the increased demand must be met from the fat already stored up in the tissues: in other words, the patient's obesity will be attacked, and he will get thinner. "If the fat destruction due to severe exertion be repeated at short intervals of time, the fat stores of the body will be encroached upon more and more, and a minimum will be finally reached beyond which we cannot go."

On the other hand, the dietary must contain a large amount of nitrogenous food. This is necessary for the purpose of restoring the integrity of the muscular fibres of the heart that are already in a weak or degenerated condition, as also for meeting the demands upon the muscular system in general depending upon increased activity.

The amount of fluids ingested must be reduced to a minimum. This reduction alone exercises an influence of no considerable importance in the removal of fat. Oertel mentions two cases in which a considerable and rapid fat reduction was thus effected, no alteration whatever having been otherwise made in the patient's dietary or mode of life. Reasoning from the fact that the deposit of fat always takes place in or upon the adventitia of previously formed blood-vessels, Oertel argues that its formation in quantity is dependent upon the occurrence of local vascular dilatations in which there is a considerable retardation of circulation. Owing to the diminution of the watery constituent of the blood, the total quantity of fluid circulating becomes reduced, the circulation is quickened, venous stasis is removed, and the conditions favorable to fat accumulation being thus altered further deposition does not take place. In addition it seems probable that the inhibition of a considerable quantity of fluid favors the absorption by the lacteals of the products of digestion, and thus indirectly aids fat formation.

The strengthening of the heart muscle it is easy to understand, must necessarily follow upon the course of systematic exercise, as already explained; the improvement in the quality of the blood at the same time by increasing its nutritional value aiding in the building up of an improved quality of muscular fibre. The additional assistance to be gained by the administration of such cardiac tonics as strychnia, digitalis and strophanthus is at the same time by no means to be despised.—A. H. Weiss Clemow, M.D., in *Press and Circular*.

ON POINTS OF AFFINITY BETWEEN RHEUMATOID ARTHRITIS, LOCOMOTOR ATAXY, AND EXOPHTHALMIC GOITRE.

In actual practice we soon discover that Nature does not provide abrupt classifications and symmetric groupings. Thus, the phenomena of locomotor ataxy depend upon distinct internal lesions, and the phenomena of goitre (whether there be exophthalmos or not) are associated with distinct external lesions. Now, some of the same phenomena are also found in a large number of cases of rheumatoid arthritis. The three diseases overlap each other, so to speak, at several points. Does not this go to prove that there is an arthritis which is essentially neutral, apart from all diathetic contamination? These curious facts have a wide significance, and are of much interest to workers in the comparatively untilled ground of rheumatoid arthritis. If it be true, as Dr. Todd said, that a knowledge of gout is a passport to all humoral medicine, it is possible that a knowledge of rheumatoid arthritis will provide a key which will open many secret avenues of neural medicine.

Pigmentation of Skin.—I believe that I may fairly claim priority in observing and recording some *differences* of rheumatoid arthritis during its early stage. These differential symptoms are striking and obtrusive. They belong to no other group of the large family of arthritis. Many rheumatoid people, belonging mostly to an age between 50 and 65, possess neither the distinction nor the energy to display nerve disturbances; but nearly every case of undoubted rheumatoid arthritis in early or middle life shows marks of cerebro-spinal sympathy in one or more ways. Look for pigment; feel the hands for cold sweats; examine the heart for quick beating and often high tension; and ask whether there be severe or paroxysmal neuralgia. The probability is great that you will catch at least one of these connotative signs. Assuming, then, that there is before you a neural arthritis with a yellow or melasmic bronzing of some part of the body usually sheltered from light, the judgment may at first lean to disease of the adrenal glands. Only for a moment need we dwell upon this, or upon the bare possibility of arsenical poisoning. To Dr. David Drummond, of Newcastle-on-Tyne, we are indebted for a record of the fact that pigmentation, like that which is associated with tuberculous disease of the adrenal glands, is a frequent accompaniment of exophthalmic goitre. The favorite situations of the discoloration are around the prominent eyeballs; on the face generally; neck, armpits, and areola of nipples; abdomen, and inner part of both thighs. The patches are sometimes clearly defined, but often they fade imperceptibly into normally

colored skin. Wherever the pigment occurs naturally, there it is found increased; and the color varies from a pale yellow to a deep brown.

Very likely these are those disturbances in the chromatogenous function of the skin which I have described as a common feature of rheumatoid arthritis. The pigment patches are more or less large; their hues are infinitely varied, and they are seen on many parts of the body. Across the forehead there may be a light bronze smear. Beneath the lower eyelids the streak is sometimes very dark, and shines with metallic lustre. The dominant tints on the face are lemon and orange and citron. Occasionally the neck looks as if it had been soaked in a walnut dye; and in one case the complexion of the face resembled that of a mulatto, and it was partially covered with a brown seborrhœa. The arms and hands are often severely pigmented.

Trousseau called attention to leucoderma as a feature of exophthalmic goitre; and in three cases of rheumatoid arthritis I have seen round white patches of skin on the front of the forearm. The pigment of arthritis assumes many forms, one of the most common being yellow spots or freckles; but these are, I believe, never seen in exophthalmic goitre. Further, a larger number of goitrous cases are complicated with discolorment of skin than cases strictly rheumatoid.

Tachycardia.—In exophthalmic goitre the disturbance of the heart's action may exist for months before any other symptom.

My original observation on the quickness of pulse which characterizes so many cases of early rheumatoid arthritis has been confirmed by distinguished physicians—Sir Dyce Duckworth, Dr. Samson, Dr. Archibald Garrod, and Dr. Pye-Smith. This form of tachycardia is not at all uncommon; certainly in every urban hospital or infirmary a case must exist now and then, and would be easily found if looked for. How is it interpreted? Is the subject of it called irritable or excitable, or is the tachycardia ascribed to old and forgotten myocarditis? What explanation is given in the official lecture room? Last November we took a kind of census of this symptom at our Mineral Water Hospital, in order to test the numerical severity of the cases of tachycardia then in the house and under my care. Of fifty-four patients occupying my beds, eighteen were unquestionable examples of rheumatoid arthritis, and nine (eight females and one male) had more or less quickness of pulse (average pulse not below 90). Now concerning the nine people above mentioned: the mean age was a trifle more than 42; four of the women were married and had children, and four were single; and the average rate of the pulse (taken in the sitting position) was 104. I have never found a material difference whether the patients were lying or standing, or after mod-

erate exercise. The heart's action is not accelerated by emotion, sudden sights and sounds, or by pain. In none of our cases was there any apparent disease of the valves or the walls of the heart. The pulse is rarely small or feeble; sometimes it might be called hard and tense. We heard no cardiac murmurs, either at base or apex. In these points there is somewhat of a contrast in the behavior of the circulation in exophthalmic goitre and rheumatoid arthritis respectively. But these diseases intimately touch one another in the frequency of the venous hum, which varies in character, intensity, and tone. It is the true vascular hum of pure anæmia and chlorosis. The anæmia of rheumatoid arthritis is of special significance in the tone of its tints and pallors, telling us in a manner not to be mistaken that scrofula and "consumption" are not far away.

In my private and hospital practice it is a matter of routine to search for an enlarged thyroid gland. The occasional coincidence of the enlargement with a moderate rheumatoid arthritis is not sufficiently recognized, but it should be sought for whenever there is a dark stain on the neck. Only one lobe of the gland may be affected. Inquiry about the behavior of the thyroid should be pushed back to early womanhood. Extreme crippling arthritis, associated with exophthalmos and "paroxysmal hurry" of the heart, occurred in an aunt of mine, my father's eldest sister. Very lately Dr. Sansom entrusted to my care a young married lady suffering badly from arthritis of a pronounced rheumatoid type; and she has a sister afflicted severely with the ocular and vascular symptoms of the so-called Graves' disease.

Tremor and Spasms.—That special upset of motorial function which is shown in tremors is common to both Graves' disease and rheumatoid arthritis. In the former there may be choeric movements of the limbs, and such a disturbance of the respiratory muscles as to cause breathlessness and almost dyspnoea. Tremblings of the head and rapid shakings of the arm are quite common in the history of goitre, and are now and then seen as a phenomenon of rheumatoid degeneration. I may quote the case of a middle-aged woman, a housekeeper, who was under my care in the summer of 1888, on account of a to-and-fro spasm of a rheumatoid left arm. The heat of the axilla on the affected side was noteworthy. To the bare touch the sensation of heat was quite acute, and on one day (a cold and wet afternoon in July) the clinical thermometer gave a reading of 100°—exactly 2° in excess of the temperature on the other side. A remarkable example of tremor occurred in a rheumatoid lady, aged 36, entrusted to my care by Dr. Andrew, of Edinburgh. A shaking of the right arm began in November, 1888, after the death of a child. It did not go on during sleep, or when she

was alone and quiet; but anything which caused surprise (whether joy or pain) began or intensified the trembling. It conformed strictly to the type of paralysis agitans, and was quite as uncontrollable.

Akin to the motorial aberration of tremor is the occurrence of muscular spasm. It is only in accordance with the analogy of compound nerves elsewhere that the motor portion of the pneumogastric nerve should be occasionally in trouble; and we see how profound this disturbance may be in the irregular movements of the trapezius muscle, and of the neighboring portion of the sternomastoid. If the partial stoppage of the inhibitive function of the pneumogastric nerve be the proximate cause of the tachycardia, we may measure thereby what the molecular shaking of the spinal accessory must be. These functional shocks of the great eighth nerve are important bonds between rheumatoid arthritis and locomotor ataxy. In the early stage of both diseases there may be the so-called gastric crises, cramp of the stomach and vomiting; a pseudo-asthma, or a transient dyspnoea; and difficult swallowing from incoordination of the pharyngeal muscles. This lack of harmonious action in the pharyngeal muscles may be so complete as to lead to regurgitation of solid and liquid food through the nostrils.

Pain.—It is in the grand element of pain that we see the closest sympathy between locomotor ataxy and rheumatoid arthritis. The pain of a rheumatoid limb may come and go in the same way. As a matter of chronology, pain now and then visits a rheumatoid patient almost before any articulate symptom can be detected. The wife of a medical man whom I saw in 1887 had a painful condition—acute and paroxysmal—of the whole right arm. There was nothing to account for it except an early and slow osteo-arthritis of the carpus and elbow-joint. In 1888 a lady was sent to me from the north of England for the treatment of sciatica. There was a melasmic smear on each temple, and the bright orange splash on the forehead. The freckles on the skin over the knee-joint told their own tale, and a careful clinical examination revealed a "grating" and a difficulty in the movements of both knee and hip-joints. The sciatica was purely secondary to the arthritic changes. I do not discuss the connection now; my plea is that it is much more than a chance event. Generally the specific rheumatoid neuralgia of the lower limb is, so to speak, pain in bulk; the sufferer clasps the thigh all round, and says that the pain is in every part of it. Sudden pains run up the arm—often beginning in a particular finger—and a grievous neuralgia, which simulates that of locomotor ataxy, is often felt in the region of the shoulder and the upper arm.

The burning and gnawing pain, the tinglings,

and the sensations of cold and heat are common to both the diseases that we are now considering. But they are linked together in the closest way by the ruin of joint structures. Much mystery has been thrown around what is called Charcot's joint lesion, as though it was a special trophic affair. Few people have, I imagine, really believed this; and it is refreshing to find that Dr. Frederick Taylor, in his excellent *Manual of Medicine*, plainly professes his belief in the identity of the rheumatoid and Charcot lesions. The same view is supported by Dr. Archibald Garrod, in his complete monograph on *Rheumatism and Rheumatoid Arthritis*; and he quotes Mr. Marrant Baker as a surgical authority on the same side.

Some Uncommon Symptoms.—I travel a little outside the title of my paper in order to glance at some erratic phenomena which cannot be formulated just yet.

Bulbar Warnings.—In early rheumatoid troubles we see, now and then, warnings and resemblances of bulbar paralysis.

Athletic Contractions.—The mimicry of athetosis in the grasp of the rheumatoid hand is sometimes most remarkable. The fingers may bend and extend without any coherence or consistency of action. Abduction and adduction may be equally irregular; and I have seen the fingers engaged in slow involuntary movements when the attention has been directed elsewhere.

Glossy Skin.—"Glossy skin" belongs to the group of dystrophies and anaesthesiae, so well described by Dr. Ord. This condition of skin—*atrophoderma neuritica*—is a common sequel of neuritis. When the fingers are affected they become smooth, shining, and dry; they taper in form, and their color is pink or red. The nutrition of the nails is more or less injured. If anything were needed to prove the inadequacy of the naked surgical doctrine that rheumatoid arthritis is a result solely of mechanical wear and tear, it would be the phenomena of glossy skin. As a sequel of pure rheumatism or pure gout, this symptom shows that rheumatoid degeneration has begun, and that it should be treated as such without delay.

The danger which lurks in glossy joints is illustrated by a petty accident which happened to me last winter. A lady of middle age, sent to me by Dr. Miller, of Fort William, had bent rheumatoid fingers, and there seemed no harm in trying to extend them by degrees. One day, however, I put her under the influence of methylene in order to apply a little more force than usual; and I had the misfortune to split the skin on the flexure side of the terminal joints of two fingers, with sudden and profuse hæmorrhage. Fortunately, I had means for staunching blood at hand, and I prudently desisted from doing anything further.

Influenza.—My last remark refers to the con-

nection between rheumatoid arthritis and influenza. In several cases I have been able to identify the beginning of the rheumatoid lesions with a severe attack of influenza in the winter of 1889-90. So convinced were the patients of the sequence of the diseases that in every instance it was mentioned to me as a fact about which no doubt could exist. The influenza passed off, but an ominous weakness was left behind. During this interregnum of depression and spanæmia a slow inflammatory process seized the carpal and tarsal articulations; there might be a gradual quickening of the pulse, but no pyrexia. There is a real danger of being led to treat these cases as if they were of the ordinary rheumatic kind; but no blunder can be more damaging to the patient or more hurtful to the credit of the practitioner. In one instance the substantial good which I had accomplished for a rheumatoid patient, an elderly lady, during three visits to Bath in 1888 and 1889, was entirely undone by a single bad attack of influenza in February, 1890; and about a year ago she came once more to Bath, somewhat in despair, and as crippled as ever.

My chief object in this paper has been to point out the lines which our clinical enquiry may most profitably take; and that enquiry may lead us ere long to a broad generalization that shall embrace phenomena now grouped under various titles. I have purposely refrained from speculation; our appropriate function is at present to collect and record facts. The work is full of interest, and there is every encouragement to go on. My debt of obligation to our Mineral Water Hospital is beyond all words; the clinical material gathered within its walls is of priceless value to the candid observer who has a "Platonic passion for knowledge," and the just mind which can sift and weigh that knowledge when found.—Dr. Spence, in *Br. Med. News*.

ON THE VALUE OF LEECHING IN SOME DISEASES OF INFANTS AND CHILDREN.

Venesection has not been used as far as I am aware in cases of infants and children, but bleeding has always been effected by means of leeches.

This useful remedy has been too much neglected of late years, and I offer a few remarks on the cases in which experience has proved its great benefit. Leeches are of most service in the treatment of pneumonia in young children, and particularly in cases of acute consolidation of the lung from exposure to cold.

As it is usual for physicians to be called in when the symptoms have assumed a really serious aspect, I can speak with most certainty and satisfaction of those cases where the conditions were of the gravest character.

In five such cases the medical advisers were of opinion that recovery could not be hoped for, and some difficulty was experienced in obtaining the permission of the parents to resort to a plan of treatment which presented the apparent objection, that in such conditions of exhaustion it could only hasten the fatal end.

This objection has probably been the chief reason why practitioners have feared to incur the responsibilities of bleeding, and some time will elapse before popular prejudice in regard to this matter will be overcome.

In one case two children, set. 3 and 5 respectively, went to Dartford to spend the Christmas with relatives of their parents. It was the year of the great snow-storm, that is ten years ago, when the intense cold was the cause of serious illness and mortality. I was met at the railway station by the medical adviser of the family, and informed that I had come too late to be of much assistance, as the youngest child had died a few hours before, and the elder could not in his opinion live through the night.

The case presented the usual signs and symptoms of excessive consolidation of the lung. There was dulness and tubular breathing over the whole of the left lung. There was doubtful crepitation at the base of the right lung. The pulse was 150, the respirations were between 60 and 70, and the temperature was 104°. All the usual remedies had been administered, and the parents had given up hope of the child's recovery. As it was their only child, the scene was one which would naturally impress itself upon the memory. In the other four cases the conditions were generally similar to those above described, and the same hopeless view was entertained on the question of recovery. The children were all under six years of age. They all recovered.

In prescribing the application of leeches in such cases as was done in those above referred to, the following directions should be given. Three or four leeches, according to the age of the child, should be applied over the right or left anterior thorax, and when the leeches fall off the hæmorrhage should not be arrested, but linseed poultices or hot fomentations should be applied for two or three hours to encourage bleeding. Probably great prostration will occur, and it is proper to support the patient generously with beef tea and port wine. After the warm applications the chest should be covered with wool, but the bleeding allowed to cease spontaneously. In two of the above cases the bleeding was arrested before this occurred, and in both it was necessary to repeat the application of leeches.

In cases of true croup, arising generally from exposure to cold, and where the symptoms are of very acute character, I have often seen great benefit obtained from leeching. When a child of

about four years of age I can recollect being treated for such an attack by an esteemed friend of the family, the late Dr. John Webster, of Brook Street, and that personal experience of the relief which followed the application of leeches has not been without effect upon the treatment I have usually advised under similar circumstances.

There is another class of cases in which great relief is generally obtained from leeches applied to the precordial region, viz., those of mitral insufficiency, and congenital heart disease, where urgent cardiac and respiratory distress demand prompt attention.

Before concluding these brief remarks I may be allowed to suggest for consideration the difference in the effects obtained from venesection as compared with leeches. This subject was carefully considered by the physicians of the early part of this century, and particularly by Dr. Wardrop in his work on "Blood-letting," (1835).

As our individual opinions on the value of venesection or leeching ought to depend on personal observation rather than on any theories we may entertain, I have confined myself to the results of my own experience.—R. Lee, M.D., F.R.C.P., in *Med. Press*.

COCAINISM.

The chief facts about cocaine in relation to cocainism are thus summarized :

1. It is the acutest and most absolute destroyer of inhibition, and of the moral sense generally, that we yet know.

2. The morbid craving is very intense, and control is absent.

3. The dose requires to be increased faster than that of any other such drug to get the same effect.

4. The delirium and hallucinations of all the senses of single doses become chronic in cocainism.

5. Its immediate effects are more transient than those of any other such drug, but this does not apply to the craving set up.

6. The treatment of cocainism consists in outside control of the patient, in stopping the drug at once, in careful watching, nursing, the use of every sort of food that will keep up the strength, and of the bromide of ammonium, brandy and wine, tea and coffee, and possibly a hypnotic, like paraldehyde or sulfonal, for two or three nights at least.

7. A patient suffering from cocaine can be usually certified as insane so far as the presence of delusions are concerned, but he gets over these so soon, and yet is so far from real cure, that certification and sending to an asylum is not a satisfactory process altogether. We need cocainism included in any special legislation for dipsomania.

The writer also considers among morbid crav-

ings and paralyzed control, masturbation, sexual perversion, morbid indecision, etc., and finally sums up the whole subject as follows :

1. That many morbid and hurtful uncontrollable cravings exist apart from those for drink, morphine, chloral, or cocaine.

2. That there is a distinct class of "inhibitory neuroses" that may be accompanied by little intellectual or emotional disturbance. The objects of the morbid cravings are often accidental.

3. Some of the most morbid cravings and examples of loss of control are found connected with the reproductive function, in regard to which, too, perversions of object are also very apt to accompany such morbid cravings.

4. For the existence of many cases of such reproductive loss of control, prostitution is probably responsible, and the unnatural habit of masturbation for many more.

5. The reproductive instinct is, in some cases, morbidly transformed into uncontrollable impulses toward suicide and homicide.

6. Cravings to break and destroy, accompanied by little intellectual disturbance, that cannot be controlled are often met with.

7. The state of morbid inaction is often closely allied to morbid impulse, one sometimes taking the place of the other.

8. There are cases where there is a morbid loss of control over general conduct, in ordinary matters, and cravings to do quite harmless acts.

9. There is a morbid condition of brain automatism, apart from hypnotism, in which there is little or no power of inhibition, but at the same time no active cravings, the conduct being regulated by the will of others, or by chance suggestion from without or within.

10. Loss of control often precedes, for some time, the other mental symptoms of an attack of active insanity.

11. Inhibition may be lost in one direction only, while in most others it may be very strong—gambling being often an example of this.

12. All brains must have some "excitement" to keep them healthy, the important question being how to select the kind of excitement that will not lead to morbid craving, and that can be easily controlled.

13. Morbid indecision may be an example of paralyzed control.

14. We may have morbid and uncontrollable muscular action, not purposive, and not attended by ideation or emotion at all.

15. It is a fact that in man's medical psychology that control is almost always lessened at night or in the darkness as compared with the day, the night being the time for morbid indecisions, fears, superstitions, and a tendency to mistake the subjective for the objective, his higher powers then undergoing a process of partial "dis-

solution." Man, in fact, is a less evolved being as regards his inhibition at night than during the day, and his brain is far more liable to disturbance of the controlling functions in disease.—*Quar. Jour. Inebriety.*

MEDICAL NOTES.

Dr. Brubaker recommends the use of the following preparation for *pruritus* :—

R.—Acid. hydrocyanic. dilut. fʒij.
Sodii borat. ʒj.
Aquæ rosæ. fʒviii.—M.

Sig.—Use as a lotion.

Prof. Da Costa states that, in the treatment of *hepatic calculi*, all sugars and starchy foods must be avoided, and recommends sodii phosphas, in one drachm doses, three times a day, in hot water.

Dr. Brubaker recommends the following prescription for *spasmodic cough* :—

R.—Acid. hydrocyan. dilut. fʒj.
Tinct. sanguinariæ. fʒiv.
Syrup. senegæ. fʒss.
Syrup. tolu. fʒij.
Aquæ laurocerasi. q. s. ad fʒviii.—M.

Sig.—fʒj t. d.

Prof. Da Costa, in the beginning of an attack of *influenza*, lays great stress on giving ten grain doses of quinine, three times a day; and as there is great depression, whisky throughout the disease. Symptoms are to be treated as they arise.

Prof. Da Costa states that, in the treatment of *chronic interstitial nephritis*, nitro-glycerine may be given in doses of two to three, or increased even to thirty drops (if necessary), three times a day. At the same time give ergot, in a half-drachm or drachm dose, three times a day.

Prof. Da Costa recommends the following treatment for *cerebro-spinal fever*: Bromide of potassium, ten grains every two hours; also opium, the very best. In cases where headache is very severe, local bloodletting by leeches or cupping is of great benefit. Laxatives should always be given.

The following prescription is claimed by Dr. Brubaker to have a greatly beneficial effect in *asthma* :—

R.—Liquor. potassi arsenitis. gtt. ij.
Potassii iodidi. gtt. x.
Syrup. tolu.
Aquæ. āā fʒss.—M.

Sig.—This dose t. d.

—*College and Clinical Record.*

ETHERIZATION IN CROUP.—Dr. F. Betz contributes an article to the current issue of *Memorabilia*, which, though founded on only one case where etherization was tried as a treatment for croup, is yet of sufficient interest to merit notice.

He commences by pointing out that in croup the tendency towards death is by no means commensurate always with the morbid condition of the larynx anatomically considered, the nervous system often playing a considerable rôle. The case he describes was that of a child thirteen months old, to whom he was called by another practitioner in order to assist in the performance of tracheotomy. The child was breathing with the greatest difficulty, expiration and inspiration being equally noisy; the hypochondriac regions were strongly drawn in at each inspiration, also the lower intercostal spaces anteriorly; the alæ nasi were working strongly, and the child kept clutching at its throat, where the larynx was very prominent, and at its ears, and twisting its head around as if there were both pain and a sense of obstruction. It would not drink or stay in bed, the face wore an anxious expression, and the head was retracted.

No membrane could be detected in the throat, and there was no sound of air entering the lungs when auscultated from behind. On the left side percussion was dull from want of expansion of the lung. Altogether the case was apparently hopeless. Notwithstanding the dangerous character of tracheotomy in children so young, preparations were made for its performance, when the writer suggested that ether inhalations should first be tried. A mixture was ordered of three parts sulphuric ether, one part acetic ether, and one-tenth part menthol, of which three drops were given as inhalation on a folded handkerchief every quarter of an hour. The idea was by means of the vapor of ether and menthol to act on the mucous membrane of the larynx, which, as is well known, lies somewhat higher than usual in croup, and thus to contract the bloodvessels, to lower the temperature of the part, to decrease œdema, to lessen secretion, and to allay the irritation in the larynx by the production of some amount of local anæsthesia. In addition to these, Dr. Betz had the further object in view of inducing partial general anæsthesia so as to give the child rest, and to allay the spasmodic contractions of the muscles connected with respiration. In a couple of hours a decided change for the better had taken place, the child, being quieter, and some air evidently entering the lungs. The inhalations were continued therefore, but at intervals of half an hour. Six hours later the respiration had become much less noisy, the contractions less, and the dyspnoea far less urgent, enabling the child to drink. The face had regained its proper color, and the child was pretty comfortable, so that there was no longer any need to think of tracheotomy. The regular administration

of the inhalation was stopped, but another mixture of a somewhat similar character, containing three-tenths of a part of menthol, was ordered, in case of any recurrence of the alarming symptoms. Fortunately the subsequent progress was so uniform that no recourse to this was required. The object of increasing the menthol was to obtain greater refrigeration and to enable it to penetrate further into the air passages. The writer remarks that Trousseau used to prescribe chloroform inhalations in croup, but he is disposed to prefer his own mixture of ether and menthol. Whether such etherization has any power to loosen false membranes further experiments must show; but when tracheotomy or intubation is for any reason inadmissible in undoubtedly membranous croup, this treatment may, he thinks, very fairly be tried. The inhalations ought not to be continuous, but intermittent, and the medical man should for the first hour or two administer them himself.

Lancet

MODERN TREATMENT OF SCIATICA.—The modern treatment of sciatica, based upon an enlightened pathology, represents a revolution in therapeutics, and varies radically with the type present. While many of the drugs and measures in use in former years are still in the neuralgic type, the pharmacopœia of sciatic neuritis is an entirely new one. A summary of the most reliable of the modern anti-neuralgic and analgesic remedies will include phenacetine, antipyrine, antifibrin or exalgine, cocaine, and osmic acid, the last two used hypodermically alone. Of these, phenacetine is by far the most reliable and satisfactory. Doses of seven and a half grains, given at four or six hour intervals, I have found quite effective, though larger quantities may be given with perfect safety, if necessary. Exalgine I have found after repeated tests, very unreliable. It is, of course, advisable to antagonize by proper medication any cachexia which may be present, and tonics, including change of air, will be found of value in all neuralgic states. A combination of iron, quinine and arsenic is a common formula, and answers quite well.

It is in the treatment of neuritis of the sciatic nerve that we have to note the most radical innovations in therapeutics, and the greatest advancement in results. It is of primary and essential importance in these cases to look for and, if possible, remove the cause. This may be either mechanical and local, or constitutional. Among the local causes may be mentioned, in addition to wounds, strains, and hip-joint disease, tumors of the pelvis, fecal accumulations, uterine displacements, varicose veins, and aneurisms. Exposure to cold may also be cited as a local excitant, though it probably acts in a double capacity. Toxic conditions of the blood give rise to a local neuritis occasionally. Lead and arsenic among the metals,

diabetic states, alcoholism, syphilis, and certain micro-organisms, as in malaria, have been cited as causes. Bury, in an article published in 1888, in the *Manchester Medical Chronicle*, called attention to the frequent development of neuritis in association with tubercular phthisis and typhoid fever. Thrombic occlusion of a local blood-vessel may be the explanation in some of these cases. Removal of the cause, where the relationship is clear, is at times all that is necessary in the line of treatment. If this is not determinable, the treatment resolves itself into three cardinal principles—the relief of pain, the antagonizing of inflammation, and absolute rest of the part. Of these three, the last is most important. The patient should not only be put to bed and kept there, but he should be mechanically restrained from exercising the function of the diseased nerve. This can be best accomplished by applying a splint, preferably a long hip-splint, extending from axilla to foot.

An ice-bag, or heat for inflammation and to hasten absorption, massage, or the continuous galvanic current to the nerve are useful in appropriate cases.—Dr. Pritchard, in *Am. Jour. Med. Sciences*.

INJECTIONS OF THE SERUM OF DOG'S BLOOD UPON TUBERCULOUS PATIENTS.—Injections of the serum of dog's blood upon tuberculous patients have been tried by Verneuil (*Le Progrès Médical*, Feb. 21, 1891), the results of which have been recently communicated by Richét to the Société de Biologie. The observations of Langlois, Hélicourt and Saint-Hilaire have been confirmed by those of Verneuil from experiments made on two cases of surgical tuberculosis.

The first one was that of a young man suffering from a pleural fistula, the result of a purulent pleurisy and a subsequent surgical operation. The patient presented a state of depression and of pronounced anorexia, and had continuous vomiting. After a dozen injections, of one or two cubic centimetres each, administered in the course of twenty days, there were noticed an increase of bodily weight, an increase of strength, and a return of the appetite. After the first few days the vomiting completely disappeared. The patient was greatly benefitted.

The second case was that of a young girl, also suffering from a fistula, as a consequence of a coxalgia. This patient, tuberculous and syphilitic at the same time, suffered from anorexia and great debility. However, after the injections, all feeling of fatigue disappeared; she ate well, and gained four pounds in bodily weight.

The preceding results agree with those previously obtained by Bertin, of Nantes, and Pick. These experimenters, however, employed in their trials the serum of goat's blood, but this does not act as a bactericide on the microbe of tuberculosis. In this relation, Nocard has reported a case of

experimental tuberculosis in a goat.—*University Med. Mag.*

THE TREATMENT OF VARICOSE ULCERS.—Dr. J. Brann states that a large experience with this class of cases has convinced him of the superior advantages of a 10 per cent. ointment of zinc in lanolin (zinc oxid. 15.0, lanolin 110.0, ung. emoll. 40.0). This is applied as follows in cases of ulcer of the legs: The surface of the ulcer is thoroughly washed with lukewarm water, carefully dried with a compress, and the salve spread on a soft piece of linen applied to the sore and retained by a handkerchief or strip of linen. The patient remains in bed until the sores have cicatrized. The good effects of this treatment soon become apparent, the pains and itching disappear, and the profuse watery secretion is arrested, the greater part of the transuded fluid being absorbed by the lanolin which has hygroscopic properties. The ointment forms a protective covering under which healing takes place, while the lanolin by virtue of its antiseptic powers prevents decomposition of the secretions. In cases of unhealthy ulcers, the application should be renewed four or five times daily for the first few days. After three or four days, the surface of the sore will be found much cleaner, and cicatrization will have occurred at the margins, and then the ointment need only be applied three times daily. Once a day, and preferably in the morning, the ulcer should be irrigated with lukewarm water and dried, and before each application any remaining secretion is removed with absorbent cotton. Since employing this treatment the author has not found it necessary to resort to skin transplantation.—*Allg. Wein. Medizin. Central-Zeitg.*—*International Jour. Surg.*

LOOK AFTER YOUR SLEEP.—Insomnia is rightly regarded as one of the marks of an overwrought or worried nervous system, and, conversely, we may take it that sound sleep, lasting for a reasonable period—say from six to nine hours in the case of adult—is a fair test of nervous competence. Various accidental causes may temporarily interfere with sleep in the healthy; but still the rule holds good, and a normal brain reveals its condition by obedience to this daily rhythmic variation. Custom can do much to contract one's natural term of sleep, a fact of which we are constantly reminded in these days of high pressure; but the process is too artificial to be employed. Laborious days, with scanty intervals of rest, go far to secure all the needful conditions of insomnia. In allotting hours of sleep, it is impossible to adopt any maxim or uniform custom. The due allowance varies with the individual. Age, constitution, sex, fatigue, exercise, each has its share of influence. Young persons and hard workers naturally need and

should have more sleep than those who neither grow or labor. Women have by common consent been assigned a longer period of rest than men, and this arrangement, in the event of their doing hard work, is in strict accord with their general physical construction and recurrent infirmities. Absolute rule there is none, and it is of little moment to fix an exact average allowance, provided the recurrence of sleep be regular and its amount sufficient for the needs of a given person. So that fatigue does not result in such nerve prostration and irritability as render healthy rest impossible.—*Lancet*.

TREATMENT OF PENETRATING WOUNDS OF THE ABDOMEN.—After a careful study of the subject, both in practice and in the experimental laboratory, I deduce the following conclusions:

1. All cases of penetrating gunshot wounds of the abdomen demand laparotomy; most others also require it.

2. The operation should be done immediately after the injury, if possible, so as to control bleeding before the patient is exhausted.

3. Any time within twelve hours may be regarded as the "time of selection," but the lapse of many hours or even days need not prevent operation, since death from septicæmia is likely to occur.

4. A condition of collapse is not an insurmountable contra indication.

5. The existence of peritonitis demands, rather than forbids, an operation.

6. In gunshot wounds Senn's hydrogen gas test should not be employed, as the indications are *always to operate*; perforation of intestine is not necessary to render the wound fatal. In other penetrating wounds the test may be employed.

7. Laparotomy is, in such cases, comparatively an insignificant operation. Any surgeon of ordinary skill ought to be able to successfully operate.

8. In case of emergency the operation here described can be made without an elaborate set of instruments. A success can be obtained by the use of only (a) a knife, (b) scissors, (c) needle and thread, (d) hæmostatics and (e) *good judgment*.—Dr. Lamphear, in *Weekly Med. Rev.*

AN EASY METHOD OF FEEDING PER RECTUM.—Mr. Y. M. Jones-Humphreys, L.S.A., writes (*Lancet*): Some months ago, having to treat a bad case of gastric ulcer by rectal feeding, etc., I devised an apparatus consisting of a small funnel, a piece of elastic tubing $\frac{1}{2}$ inch in diameter, $1\frac{1}{2}$ feet long about 4 inches of glass tubing (by which the descending fluid can be watched), and joined on to this an ordinary flexible catheter. The atmospheric pressure is sufficient to send any fluid into the rectum, and I have never noticed any

return of the fluid, absorption being slow but efficient. The instrument is an improvement on the old enema apparatus in use. The claims for this method are: (1) It is extremely simple, the patient being able to pass the catheter into the bowel without experiencing any pain or unpleasantness: (2) It is cheap and easily made: (3) After once being shown, the most inexperienced person can use it, and thus we can be sure our patient will have small quantities of nourishment at frequent intervals: (4) The fluid is slow in its passage, and thus nearly the whole quantity becomes slowly absorbed. In any case requiring rectal feeding, I venture to hope that my professional brethren will find this simple method of use to them, and a source of comfort to their patients.—*Hospital Gazette*.

VIBURNUM PRUNIFOLIUM IN DYSMENORRHEA.—

Since its introduction to the profession fifteen years ago, *viburnum prunifolium* has held its own as a remedy for dysmenorrhœa against many drugs then lauded to the skies, but now long forgotten. It will certainly relieve dysmenorrhœa, if the testimony of thousands of intelligent physicians is worth anything. In the nervous phenomena of the climacteric it will diminish reflex activity, acting in precisely the same lines as the bromides, but without the great general depression of their long continued use. Alone, it is not sufficiently sedative to relieve pain, but more more markedly anti-spasmodic remedies—such as hyoscyamus, cannabis Indica, camphor, and conium—must be employed.—*N. Y. Medical Journal*.

PRURITUS OF THE VULVA.—Tarnier gives the following formula:

R.—Hydrargyri bichloridi, 30 grains.
Alcoholis, 2½ drachms.
Aquæ rosæ, 10 drachms.
Aquæ detillatæ, 30 drachms.

M. et ft. sol.

This lotion is applied in full strength morning and evening, in the vulva pruritus of pregnant women. The lotion may cause, at first, a severe smarting, necessitating the use of cold water after the application, but the smarting gradually disappears on continued use, and the pruritus is soon relieved.—*Jour. de Med. de Paris*.

LEUCORRHE.—J. D. Ebert, M. D., Dundee, Ind., says:

R.—Vaseline, 1 ounce.
Golden seal, 1 drachm.
Listerine, 1 drachm.

Mix all together and stir briskly while being warmed to reduce the vaseline to a fluid state. Sig.—Use freely on cotton tampon once or twice a day.

THE CANADA LANCET

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ASEPSIS A LA MORT.

The profession generally does not suffer as much as do medical editors, from the tiresome reiteration of the names of certain fads, recent discoveries, new methods, and specifics. But any medical man who reads his journals, and we opine that but few of the profession are without more than one, must sometimes grow weary of the repetition of such terms as Pasteurism, Koch's lymph, asepticism, etc. How great then should be the commiseration felt for the medical editor, who, week after week, from year's end to year's end, is obliged to have passed before his vision these same terms, world without end, in scores of exchanges? "Koch, and Lister, and Senn; Senn, and Lister, and Koch;" —, till the brain begins to swim.

But the journal must be kept abreast of the times and so there is no respite; for the *clientele* must know, so far as the editor has the power and opportunity to inform them, all that is new and strange, as well as all that is old and practical and of daily use in the science and art of medicine. Perhaps being only human, he sometimes comes wrongly to the conclusion that his readers are as weary of the grind as he is, and so leaves some of the newest fads severely alone. Kochism is dead. Why then weary his readers with dissertations on a defunct subject? Pure antiseptic treatment—pure asepsis means *cleanliness* and nothing more. Why keep the asepsis stop always turned on?

Then the ridiculous suggestions made by the

ultra aseptics are a weariness and a burden, when will they come to be repeated *ad infinitum*. There is a deal of truth in the remark of the sailor who had been on a whaling voyage, that "pork and beans for dinner for fifty or sixty days running is very nice, but when the same articles were served for that repast every day for three years, the result produced was a slight sense of monotony."

The latest question regarding asepsis is that proposed and seriously discussed by an American contemporary, viz., as to whether nurses should be allowed to attend surgical cases while menstruating. It is said that several surgeons at Chicago and New York are so impressed with the septic properties of menstruating nurses, that they have excluded them from all major operations. The reason urged is, that menstrual blood is already partially disintegrated, and that it rapidly becomes offensive. This is true, but it is also true of other excretions, as urine, feces, or perspiration. So if menstruating nurses are to be excluded, so ought, according to the principle, perspiring men, or men who had —, but it is unnecessary to carry the comparison further.

If the suggestion, or alleged practice, be carried out, it will prevent female nurses attending to their duties as attendants on surgical cases for about one-fourth of the time, a very serious aspect of the question to them. Lawson Tait "cannot conceive of anything more ridiculous" than such suggestion; and we, for the sake of the common, hen sense of humanity, trust that this fad may soon be relegated to its proper place with those that "have had their day and ceased to be."

THE LITERARY EQUIPMENT OF THE AMERICAN MEDICAL MAN.

(Continued from June No.)

To return from this digression. The great fault of most writers on medical subjects is a very slovenly and inaccurate use of terminology, due to dense ignorance of the most rudimentary Latin and Greek. One of the cleverest and most useful little works on the practice of medicine, written by one of the most successful teachers on the staff of so really good an institution as the Jefferson Medical College, Philadelphia, and dedicated to no less eminent a physician than Dr. Costa, abounds with such barbarities as these: *argentum*

nitras, "the use of diaphoretics are," *retinitis albuminuria*, *lithi citras effervescentes*, *sodii salicylicum*, *calcii sulphide*, and so on. The amusing part of it is that the worthy and really able author starts in with the stern determination to use Latin names or nothing for his drugs throughout.

Harper's Magazine for May, contains an interesting article on Bacteriology, written in popular style, by a bright and prominent American bacteriologist. The article is redolent of enthusiasm in the work, and sympathetic, broad intelligent interest in the subject, and shows intellectual and literary capacity much above the average. Yet the author shows the cloven hoof of neglected primary education more than once. He uses, for instance, "micro-organs" and "micro-organisms," as convertible terms, succumbing to the inevitable desire of his nation to shorten things and crowd as much as possible into life, even at the expense of scholarship and accuracy.

A paper read last year before the American Medical Association, by the Professor of Medicine, in the leading Medical College of the western slope, an M. A., M. D. of Jefferson College, Philadelphia, the author of half-a-dozen text books, and evidently a thoroughly efficient medical man, contains numberless instances of the same deficiencies of early training. His paper is a very clear defence of "American vs. European Medical Education," but he talks of "some *backwards* settlement of Canada," "men who wear *decolletè* shirts and dress in the most *blazè* style." It may be that the last French adjective is meant to veil a pun. In spite, however, of these deficiencies, the profession is moving gradually onward and upward. In Canada, especially in Ontario, the literary standard is higher even than in Britain, that is to say, the literary standard as determined by examination rather than by antecedents, family training, and associations, for it is a trite and disagreeable truth that many of our graduates in Arts can neither speak nor write decent English, such is the *vis inertiae* of early associations. The Council of the College of Physicians and Surgeons of Ontario made a move in this direction when, during the recent session of the Local House, they sought legislation empowering them to demand an Arts degree as a preliminary to entering upon the course of medical study prescribed by them, *when in their judgment, the time*

should have arrived for so raising the standard.

Their request was, we think wisely, refused, but it shows that the profession is, of all classes in the community, least satisfied with itself and most conscious of its own needs and defects. The standard will, however, soon reach that point in Ontario. One object in raising it will be the prevention of the over-crowding of the profession. Another way of attaining the same end would be the raising of the fees. But the feeling is that such a course would favor the rich, and too often idle, slipshod students, at the expense of the man who alone is fit to enter the profession and adorn it, the man whose purse may not be equal to the demands of a very high tariff of fees, but who is quite willing to work through a course of any length, preliminary and professional, so that it be thorough and gratifying to his student instincts.

* The above was written before the late meeting of the Ontario Medical Association.

TREATMENT OF THE NIGHT SWEATS OF PHTHISIS.

Huchard reports in the *Rev. Gén. de Clin. et de Thérap.* the results with many medicaments tried for the relief of the sweating of phthisical patients (*Boston Med. and Surg. Jour., London Medical Recorder.*) Among these may be mentioned lead acetate, tannin, phosphate of lime, ergot, atropine, and muscarine. Of these the two first are unreliable, and are seldom used. Probably atropine sulphate is the most valuable (one-half to one milligramme at night). Phosphate of lime should be given in large doses (one or two drachms daily) to produce anhidrotic effects, and even in these doses it has several times failed. Ergot (fifteen to twenty-two grains of the powder at night) is much more reliable. When the sweats co-exist with more or less marked fever, the author recommends the use of quinine combined with ergot.

R—Quinæ sulph. gr. xvi.

Pulv. ergotæ ʒss.

Divide into four cachets—two or three to be taken daily.

This formula is especially valuable in phthisis with hæmoptysis. Lastly, powdered agaric is an excellent remedy, not equal to atropine, but perfectly harmless, and never causing derangement of digestion. It may well be combined with

tannin or belladonna, given in doses of three or four grains.

The same writer speaks very highly of antipyrin in the initial fever of tuberculous patients. The older drugs, quinine, tartar emetic, salicylic acid, all fail, or have but slight effect. It is especially in this *initial* fever that antipyrin is of great service. One must, however, distinguish between an *analgesic* and an *antipyretic* dose of the drug. To obtain the former effect, one would give a large dose, say (fifteen to thirty grains) in a short time, but this must not be done if its best action as an antipyretic is desired. It is well for this purpose to use constantly decreasing doses (say sixteen grains, twelve grains, eight grains), taking care to divide them so that at no time during the twenty-four hours is the patient not under the influence of the drug. Used in this way, Huchard declares that antipyrin seems to have a *special* action on the tuberculous lesion, and to greatly retard or to arrest its progress.

Professor Combemale (*Bull. Gén. de Thérap.*, Jan. 15, 1891), has used tellurate of sodium, in phthisical and other sweating. It was first recommended by Neusser who gave one-third or two-thirds of a grain in pill once daily. Combemale gave it up to nearly one grain per dose, and tried its effects in eleven cases. His conclusions are, it is a powerful anti-sudorific; a dose of nearly one grain gives the best results; it gives rise to digestive troubles, and especially to a strong garlic odor in the breath. All the compounds of the tellurium cause a very disagreeable odor in the breath, and this must always be a bar to their employment, as it is very persistent and disagreeable.

In addition to the list, sulphonal has been used with success by a few reporters.

THE ONTARIO MEDICAL COUNCIL.

The late meeting of the Ontario Medical Council was a very interesting one. The most important legislation was in regard to the course of medical study. The committee appointed to report on the proposed changes in the curriculum, seems to have taken great pains to gather information regarding the medical course in various countries, of course looking to Great Britain as the one to

be emulated as far as possible. They had the satisfaction of seeing their report pass, with some slight amendments only.

In the rough, the course now consists of a matriculation, which is the Departmental University Matriculation in Arts, with Latin compulsory, and the Science subjects as well; together with a course proper.

The number of years to be spent in the medical course proper is *five*. Each student must attend four full winter sessions of six months each, and one summer session. Of the fifth year, which is the practical year for the student, *six months* must be spent in a scientific laboratory, working at physiology or pathology, or in a hospital; while the remaining six months may be spent either with a practising physician or in a hospital.

Graduates in Arts who have taken the Science Course will be required to take only three years' lectures and one summer session.

The examinations have also been changed. Under the new regulations the Council will conduct three examinations, viz.: a primary at the end of the second year, on subjects taught in the first and second years; an intermediate at the end of the fourth (third for Science graduates in Arts) year, on all final subjects, written and oral; and a final at the end of the fifth year, which shall be practical and oral only.

As to lectures, the number of those purely didactic has been reduced about one-half, and the amount of practical laboratory work has been increased. Of course any College may give as many didactic lectures as it pleases, but only about fifty per cent. of the number originally required by the Council will now be required.

The above will give our readers a fair idea of the amended curriculum. We understand that a full report of the proceedings will be sent to each member of the profession in Ontario. This, while expensive, will be, we are sure, eminently satisfactory, as it will enable the profession to know the details of business transacted at each meeting of the Council.

The change to a five years' course is a serious one, and we do not feel called upon to discuss it at length. It is sufficient to say that even in England, with all its wealth, and opportunity for study and culture in the students' early years, the five years' course is only an experiment, and

has provoked a great deal of discussion *pro* and *con*. Whether it will be a success even there remains to be seen. Are we old enough in Ontario, are we rich enough, and are the prizes in the profession sufficiently high to warrant our Council adopting a five years' term of study, after a preparatory or matriculation course which, as it now stands, is perhaps more exacting than in any other country in the world? We understand that certain members of the Council advocated even a much more stringent matriculation; to wit the senior departmental leaving examination. It is a matter for sincere congratulation, that such ultra, and we think utterly impracticable measure did not pass.

The wisdom of leaving all practical examinations till the end of the fifth year, may be doubted. From a pretty extended knowledge of students we are inclined to think that their development will be somewhat onesided by the present arrangement, and that the tendency will be for them to do little hospital or practical work until the fifth year. This, however, is a matter which cannot, with anything like reasonable certainty, be forecast. We can only hope that the change may be, as it is intended, for the interests of medical education, and that Ontario may continue, as she has done in the past, to send out large numbers of thoroughly equipped medical men to all parts of the world.

THE ONTARIO MEDICAL ASSOCIATION,

The meeting of this, the most important Medical Association in Canada, was in every respect a success. The social side of these gatherings was enhanced by the luncheon tendered to the visiting members by the Toronto members. The affair was, while not at all elaborate, quite a success, and did much to promote the friendly and social spirit which prevailed the whole meeting. The papers read were, as a whole, better, and the discussions more general, and, we think, more interesting than at any previous meeting. The greatest harmony prevailed, and there can be no doubt that all who attended the various sessions were benefited by the discussions and stimulated to further effort.

The president, Dr. Moorehouse, of London, performed his duties in a manner acceptable to every one. His address was listened to with pleasure

and profit by a large number of members. A full report of the meeting will be found in another column and many of the papers read will from time to time appear in this journal.

The choice of Dr. R. A. Reeve for President for next year was a wise one, and we may safely affirm that a more acceptable man to the whole profession of Ontario could not have been elected.

TREATMENT OF BED SORES.—Billroth is stated (*Columbus Med. Jour.*), to apply the following treatment for bed sores: Upon the appearance of reddening of the skin, he applies a lotion of vinegar or lemon juice. If excoriation is present, he applies nitrate of silver, and protects the part by zinc ointment or soap plasters. Where gangrene comes on, antiseptic compresses are to be applied, the wound being cleaned by the use of chlorine water, or carbolated oil may be used with care as the phenomena of intoxication may appear. Internally, he employs supportive treatment with wine acids, quinine and musk.

RINGWORM.—The following is good in obstinate cases of ringworm of the body:

R.—Hydrarg. bichloridi, . . . gr. ij.
Tr. benzoin co., . . . ʒ j.—M.

Sig.—Paint over the affected parts daily for two or three consecutive days, taking care not to cover too great an area or to paint excoriated parts.

FUMIGANT FOR ASTHMA.—Plant (*La Sem. Méd.*):

R.—Stramonium leaves, } of each . . . ʒ j.
Green tea, }

Lobelia inflata, . . . ʒ ij.

Add a saturated solution of potassium nitrate, dry, and preserve in a well-stoppered bottle. A teaspoonful suffices for a fumigation.

OLIVE OIL FOR GALL STONES.—Prof. Germain Sée believes that the fatty acids contained in olive oil dissolve the cholestrin of gall stones. That it is efficient in removing them there can be no doubt. It must be given in large doses.

CREOLIN IN DISEASES OF THE NEW BORN.—The substance, which goes under the names of *liquor antisepticus*, and Jeye's disinfectant, is now quite extensively used as an antiseptic, germicide and deodorant. It is used in solutions of a strength of 5 to 20 in 1000, as an ointment, 1 to 3 in 100

of lard, and on a dry dressing, 2 to 4 in 100 boric acid. Dr. Schwinz (*Rev. Méd.*) gives the following results in certain diseases of the new-born, in which he has used it :

1. Purulent ophthalmia of the new-born. In ten cases irrigation was practiced with a 1 per cent. solution. In only two of the cases was the inflammation not of a severe character, and in these the cure was complete in four to six days. In the other eight cases the treatment was continued four or five weeks without perceptible improvement, after which treatment with boric acid and nitrate of silver was used. The use of the creolin was more or less painful.

2. Muguet. In eleven cases which had been treated for a long time with chlorate of potassium, permanganate of potassium, boric acid, etc., irrigation of the mouth and pharynx for five to seven days with a 1 per cent. solution of creolin produced a complete cure.

3. Omphalitis of the new-born. Applications of pure creolin were made in several cases of umbilical periphlebitis, and all traces of the inflammation disappeared in four days.

4. Erysipelas of the new-born. The erysipelatous patches were rubbed twice daily with pure creolin with the most satisfactory results. In no case was there any evidence of poisoning.

5. Acute gastro-enteritis. Creolin was used in five cases of this disease, the following formulæ being employed :

R.—Creolin, gtt. ij-ijj.
 Aq. Canellæ, fl ʒ xx.
 Spts. Guimauve, fl ʒ v.—M.

S.—A teaspoonful every hour.

R.—Creolin, gr. vij-xv.
 Sacchari, gr. lxxv.

M.—et. ft chart, No. X.

S.—One or two powders daily.

In almost all the cases the bad symptoms disappeared in three to six days.

6. Surgical diseases in young children. A $\frac{1}{2}$ to 1 per cent. solution of the creolin will produce perfect asepsis of all surfaces and cavities where used, and will be followed by no symptoms of intoxication, as is sometimes the case after the use of sublimate.

THE ANTI-VIVISECTIONISTS IN ENGLAND.—The London correspondent of the *New York Times*

(*Med. Rec.*), sends the following as showing how the Government is inclined to deal with scientific matters there : “The principal biologists and scientists of England, headed by Lubbock, Lister, Lockyer, Playfair, Roscoe, and others, to the number of one hundred and fifty, and backed by strong letters from Huxley and Tyndall, yesterday waited on Sir Michael Hicks-Beach, President of the Board of Works, for a second time, to beg that a license be found for the British Institute of Preventive Medicine, and for a second time met with a refusal. Their eloquent speeches laid stress upon the national disgrace of a situation in which English students of bacterial growths were compelled to go to Paris, Berlin, and Vienna to study their science; and intelligent inquiry and experimental research were forbidden on English soil, as if it were an impious thing to seek for wisdom in the science of saving human life. Sir Michael Hicks-Beach gave an evasive and roundabout reply, which the *London Times* editorially translates as meaning that the anti-vivisectionists have many times more votes in England than all its men of science put together. English laws pay great attention to conserving the rights of rich men to breed hares, rabbits, and game birds for annual slaughter and maiming by shooting parties, but they sternly punish a man of science who chloroforms one of these rabbits for purposes of experiments, having no earthly purpose but to increase knowledge as to saving human life. But without these grotesque paradoxes this wouldn't be England.”

ANTIPYRIN IN EPILEPSY.—Dr. McCall Anderson has recorded a case (*Lancet*), under the heading, “Case of Epilepsy Cured by Antipyrin.” The patient was a boy aged nine years, who had been subject to fits for two years and a half. The first fit occurred six weeks after a fall. At first they occurred from four to six times daily, but later they had been much more frequent, occurring as often as from thirty to forty times a day; there was also paresis of the right arm, and, after this had recovered, of the left. Three months afterwards, the fits entirely ceased after the application of blisters to the head, and they remained absent for fifteen months. They began again, however, seven months before the patient's admission to the hospital, and he had as many as thirty or forty, or

even fifty a day. Just before admission, however, they had decreased in frequency, only occurring about twelve times in the day. On admission on December 20th he was put on five grains of antipyrin three times daily, and this dose was increased gradually until January 9th, when the dose had reached twenty-five grains. This was continued until January 16th, and then reduced to twenty grains, and again increased on the 28th to twenty-five grains. During the first six days the average number of fits per diem was 16.5, in the next four it was 13.2, on December 31st he had ten, and on January 1st the same number; on January 4th three fits, and then none till January 28th, twelve days after the antipyrin was reduced, when he had one slight fit. The dose was again increased, and no fits occurred when the last report was received on March 12th. While we have to congratulate Dr. McCall Anderson on the excellent result in this case, which he ascribes entirely to the antipyrin, we would demur in the first place to his description of the result as one of cure, and we should also be inclined to ascribe at least some of the benefit received to the changed conditions in which the patient was placed. It is always difficult to say that an epileptic is cured, and this is especially difficult in the case of a patient who has had a period of freedom from fits of fifteen months' duration on a previous occasion, and subsequent to therapeutic measures entirely different to those employed on this occasion; we should, therefore, hesitate to accept the case as one of cure until a much longer interval of time had elapsed.

THE NATURE AND TREATMENT OF ANGINA PECTORIS.—The *Practitioner* contains Dr. R. Douglas Powell's able paper on this subject (*N. Y. Med. Jour.*). The author believes that angina pectoris rests upon a neuro-pathological foundation, in which the characteristic symptoms range between the wide limits of remedial functional disorder and fatal organic lesion of the cardio-vascular system. Arterial tension is an essential element in the majority of cases. The influence of habitually increased arterial tension in producing at first functional disturbance and ultimate organic lesions of the heart and vessels is great, and the results are widespread and disastrous. The mechanism of vaso-motor angina is paroxysmally

increased blood-pressure from spasm of the systemic vessels. There may be intense suffering, and a fatal result without any heart lesion discoverable before or after death. Digitalis combined with nitro-glycerin and nervine tonics or sedatives are of great value. Nitrate of amyl and nitro-glycerin are specially useful in grave cases where there is a definite cardiac lesion. Angina pectoris, which is a disturbed innervation of the heart or vessels, may be arranged for convenience into four groups or manifestations:

1. Disturbed innervation of the systemic or pulmonary vessels, causing their spasmodic contraction and, consequently, a sudden excessive demand upon the propelling power of the heart, violent palpitation or more or less cramp and paralysis ensuing, according to the reserve power and integrity of the organ—*angina pectoris vasomotoria*.

2. Essentially the same mechanism, but with the same excessive demand made upon a diseased heart—*angina pectoris gravior*.

3. The trouble may commence at the heart from irritation or excitation of the cardiac nerves, or from sudden accession of anæmia of cardiac muscle from coronary disease—*primary cardiac angina*.

4. In certain condition of the blood, or under certain reflex excitations of the inhibitory nerves, always, however, with a degenerate, feeble heart in the background, we may observe intermittence in its action prolonged to syncope—*syncopal angina*. This group would include the *vagus angina pectoris* of Ross.

TEMPTATIONS OF QUACKERY.—Says the *Med. Rec.*: A woman physician of this city is said to have expressed the following views: "It takes a deal of conscientiousness to keep a physician from becoming a quack. It's such an easy thing to quack when you know your patient wants you to, and that because the patient wants it, it would perhaps be beneficial in the end. By quacking I mean resorting to clap-trap and unscientific methods, such as the faith cure and its like. No one but a physician has any idea how great a demand there is for this among intelligent people. They don't want the honest, straightforward exhibition of the action of drugs on the body. They want a mystery about it, an exhibition of healing as a divine force—something that appeals to the imagination. And be-

cause it is a subject for the imagination the demand comes not from the ignorant and unthinking, but from the most intelligent and best-informed people. I have known some of the most logical and clear-headed people in this city to offer such a resistance to scientific rational measures in medical treatment and insist so strongly upon some illegitimate and inadequate course, as to put the honest physician's patience to its last resorts. It isn't quite that they like to be humbugged. They don't know it for that, though the physician does. They want something for the imagination to work on. And that's the stronghold of the quack practitioner. It takes an honest man or woman to practise medicine honestly."

HUXLEY ON THE AIM OF LIFE.—In a recent autobiographical sketch, Professor Huxley says (*Med. Rec.*): The last thing that it would be proper for me to do would be to speak of the work of my life, or to say at the end of the day whether I think I have earned my wages or not. Men are said to be partial judges of themselves—young men may be, I doubt if old men are. Life seems terribly foreshortened as they look back, and the mountain they set themselves to climb in youth turns out to be a mere spur of immeasurably higher ranges when, with failing breath they reach the top. But if I may speak of the objects I have had more or less definitely in view since I began the ascent of my hillock, they are briefly, these: To promote the increase of natural knowledge, and to forward the application of scientific methods of investigation to all the problems of life to the best of my ability, in the conviction, which has grown with my growth and strengthened with my strength, that there is no alleviation for the sufferings of mankind except veracity of thought and of action, and the resolute facing of the world as it is when the garment of make-believe by which pious hands have hidden its uglier features, stripped off. It is with this intent that I have subordinated any reasonable, or unreasonable, ambition for scientific fame which I may have permitted myself to entertain to other ends; to the popularization of science; to the development and organization of scientific education; to the endless series of battles and skirmishes over evolution; and to untiring opposition to that ecclesiastical spirit, that clericalism, which in England, as every-

where else, and to whatever denomination it may belong, is the deadly enemy of science.

PASSAGE OF THE BACILLUS OF TUBERCULOSIS FROM THE MOTHER TO THE FŒTUS.—Birch-Hirschfeld and Schmorl (*Beitrag zur Path. anat. und zur allg. Path.—Br. Med. Jour.*), have put on record a case which they claim is the first in which it has been definitely proved that in the human subject tubercle bacilli pass from the mother to the fœtus. The patient was a young woman who, shortly after the commencement of her first pregnancy, began to show signs of phthisis; these gradually became more marked, and she succumbed at the seventh month of her pregnancy. Immediately after the death of the mother the fœtus was removed by Cæsarean section. The necropsy on the mother showed abundant evidence of phthisis; not only in the lungs, but in other organs, tuberculosis was detected. Although the fœtus had been alive shortly before the death of the mother, it was dead when it was removed. The chest was at once opened, but there was nothing noteworthy about the lungs. The fœtus was then taken to the laboratory, the surface of the abdomen was washed with per-chloride of mercury, and the cavity was opened with sterilized knives. No tubercles could be seen on any of the organs. Minute pieces of the liver, the spleen, and the kidney were placed in the abdominal cavity of two guinea-pigs and a rabbit, with all antiseptic precautions. One of the guinea-pigs died in fourteen days, and tubercles were found in the different parts of the abdominal cavity. The second one was killed about six weeks after inoculation, as it was clearly ill, and many tubercles were found in the peritoneal cavity. The rabbit lived three months; on its death many tubercles were found in the liver and the lung. Tubercle bacilli were found in the umbilical cord and the blood of the umbilical vein.

CHRONIC LARYNGITIS.—

R—Ext. Pinus Canadensis (dark), (S. H. Kennedy's), ʒj.
 Drosera rotund, ʒ ss.
 Glycerine (pure), ʒ iv.—M.
 Sig.—15 to 30 drops, three or four times per day. Also in nasal catarrh it is almost a specific

MENTHOL.—In most varieties of pruritis, whether general or local, the following lotion is quite reliable :

R—Mentholis, ʒ j.
 Spts. vini rect., ʒ j.
 Aquæ, ʒ ij.
 M. et add.
 Acid acetic, dil., ʒ v.—M.
 Sig.—Apply with a sponge as required.

In localized skin diseases where an antipruritic ointment is needed, the following is a good combination :

R—Campho-phenique, ʒ j.
 Mentholis, ʒ ss.
 Ung. aq. rosæ, ʒ j.—M.

Books and Pamphlets.

THE POCKET MATERIA MEDICA AND THERAPEUTICS; a *Résumé* of the Action and Doses of all Official and Non-official Drugs now in Common use. By C. Henri Leonard, A.M., M.D., Professor of Medical and Surgical Diseases of Women and Clinical Gynæcology in the Detroit College of Medicine. Cloth 12mo., 300 pages. Price, postpaid, \$1.00. Detroit: The Illustrated Medical Journal Company. Toronto: Carveth & Co.

This volume has been in preparation for the past four years. A description of the drugs of as late an introduction as 1891 are to be found in its pages. The author claims to have operated everything of merit, whether official or non-official, that could be found either in standard works or from many manufacturers' catalogues. The scheme embraces the Pronunciation, Official or Non-official indication (shown by an*), Genitive Case-ending, Common Name, Dose and Metric Dose. Then the Synonyms, English, French and German. *If a Plant* the Part Used, Habitat, Natural Order, and Description of Plant and Flowers, with its Alkaloids, if any. *If a Mineral*, its Chemical Symbol, Atomic Weight, looks, taste, and how found, and its peculiarities. Then the Action and Use of the Drug, its Antagonists, Incompatibles, Synergists and Antidotes. Then follow its Official and Non-official preparations, with their Medium and Maximum Doses, based, so far as possible, upon the last U. S. Dispensatory. Altogether, it is a handy volume for either the Physician, Student or Druggist, and will be frequently appealed to if in one's possession.

SURGICAL BACTERIOLOGY. By N. Senn, M.D., Ph.D., Professor of Surgery in Rush Medical College, Chicago, and in the Chicago Polyclinic, etc., etc. Second edition, 1891. Philadelphia: Lea Bros. & Co. Toronto: Carveth & Co.

This book of 270 pages will be welcomed by the profession as coming from one of the authorities of the day, in surgery. Dr. Senn's name is so generally and so favorably known to our readers that we need give the present book no other endorsement than to say that it is worthy of its author. In the preparation of this edition the author has added new facts illustrative of the relations of pathogenic micro-organisms to the various surgical lesions, and eight new illustrations have been inserted in the text descriptive of microbes not illustrated in the first edition. The book has also been divided into chapters, which it is hoped will prove useful for a better classification of the material and for more ready reference.

THE STAINING AND IDENTIFICATION OF TUBERCLE BACILLI.

We notice that a Mr. Baker, of London, has fitted out a small box 8 x 6 x 4 inches, containing all the necessaries for the immediate discovery of the tubercle bacillus. The idea is a good one, and we hope that some enterprising Canadian may follow as a good imitator, if indeed there be not something of the kind already under way. The usefulness of such apparatus in many cases of difficult diagnosis, is obvious.

COSMETICS, a Treatise for Physicians and Pharmacists. Being a translation of Dr. Heinrich Paschke's work. New York: William Wood & Co. Pp. 286, \$1.50. Toronto: Carveth & Co.

The work contains about 300 formulæ for the preparation of all kinds of cosmetics, and will be of service to any one desiring a knowledge of the subject. Dr. Paschke is docent at the University of Vienna, and has made the work a successful one.

THE MODERN ANTIPIRETICS; their Action in Health and Disease. By Isaac Ott, M.D., Ex-fellow in Biology, Johns Hopkins University, etc. Easton, Pa.: Vogel. Toronto: Carveth & Co. 1891.

A useful *résumé* of the properties, doses and therapeutic indications of the coal-tar products.