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THE CANADA LANCET.

A MONTHLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

VOL. XVI. TORONTO, MAY., 1884. No. 8.

Original Communications.

CASE OF INTERSTITIAL FIBROID TUMORS OF THE UTERUS.

BY JAMES FERGUSON, M.D., CUMBERLAND, ONT.

On the 18th August, 1882, I was called to see Mrs. McD., aged 42, married 13 years; never had any family; never had been pregnant. Found her suffering severe pain and in great distress from a swelling or "hard lumps," as she called them, in her bowels. She described her pain as excruciating, preventing her from sleeping, taking away her strength and unfitting her for work. She looked the picture of anxiety and distress. I elicited the following as to her previous history. From a girl had always painful menstruation, habitually constive, and suffered much from wind in bowels, otherwise had good health; never any severe sickness, and was until a few days ago able to look after the house and dairy work of a large farm; had been a hard worker, and in harvest time would pitch grain and help generally at field-work. For two years previous had felt more or less dragging-down pains and sense of fulness in lower part of abdomen, but never experienced any great inconvenience apart from her usual dysmenorrhœa until 1st June last when she felt a hard lump just above the pelvis. This rapidly increased. In the two and one-half months which had elapsed from the time she first felt it until I saw her on 18th August, she had enlarged to the size usually attained in a case of utero-gestation at the fifth or sixth month. She had been examined by a physician who pronounced her case ovarian tumor, and advised her to go to Montreal and have it operated on. Before doing this, her husband sought my advice, and on examination I found her as before stated, careworn, and in much suffering, but not presenting the "facies ovariana" so characteristic of ova-

rian tumor. On passing my hand over the abdomen with slight pressure with the finger, I could easily make out at least three distinct, hard, unyielding, uneven knob-like masses, tender to touch, perfectly free from fluctuation and not moveable, but greatly distending the abdomen; no tympanitis. The abdomen though much distended was unevenly so, the bulk of the protuberance being above and to the left of the umbilicus per vaginam. I felt for the os uteri but could not find it digitally, and with my speculum succeeded no better; ordered her to remain quiet in bed, (up to this time she had been going about every day when able), and on no condition to leave it till I saw her again; gave her morphia and bromides, to relieve pain, and a good diuretic for the dysuria which was now troublesome, and left her. Returned on third day and succeeded in finding the os which was tilted back; when brought into the field of vision it looked healthy but small as a virgin's, hard, rigid and unyielding, and although I tried with patience and perseverance, I could not introduce the sound into the cavity of the uterus. Fearing that I might have a case of fibroid polypus to deal with, I did not use extra force with the sound, but as the rest and quiet with the soothing treatment, had had the desired effect in controlling pain, I left her on the same, adding, thereto a mixture of sulph. mag., bi-tart. potas, and tr. ferri to be taken every second or third morning as required. By the middle of September, under a tonic and supporting treatment, she had gained some strength. I repeated my attempt to introduce the sound, and with some trouble succeeded, when I found the uterus slightly anteverted, and elongated to the capacity of three and a-half inches, and the cavity of the womb pressed upon by hard resisting tissue on each side. I could detect no polypus or intra-uterine fibroid, and satisfied myself that the tumors were not *inside* the womb. That they were not ovarian I inferred from the hard, rigid, almost bone-like feeling, and the entire absence of any fluctuation in and the immobility of the mass—it could not be polypus as there was an almost total absence of bleeding after my prolonged use of the sound inside the womb; but the rapid growth which had taken place in two and one-half months, together with the great pain experienced, left me in doubt as to the benign or malignant character of the tumor

which I now diagnosed to be in the walls of the uterus. As Mrs. McD. had suffered so much and so long from dysmenorrhœa, I continued the dilatation of the os uteri until I satisfied myself that the canal of the cervix was sufficiently enlarged to allow of the free flow of the menstrual discharge which had always been painful and prolonged, and a time by her much dreaded. I pursued the method laid down by the late Dr. Sir J. Y. Simpson, of Edinburgh, and the sequel proved the correctness of the course adopted, as she menstruated on the 18th to 20th of same month, September, 1882, and under the influence of a pill or two of henbane and belladonna, with the bromides she passed through the period with unwonted ease and comfort—still kept her quiet and in recumbent position, on general supporting treatment, never being able to suspend the bromides or morphia. She became fairly comfortable. Although I had diagnosed fibroid tumors of the walls of the uterus yet, fearing from the rapid growth of the mass and the unceasing character of the pains in the tumors, that they might be malignant, I determined on a consultation, and on the 7th of October Dr. Trenholme, of Montreal, who has made a specialty of diseases of women, saw Mrs. McD. with me. To our intense surprise we found it impossible to introduce the sound, and had to be satisfied with what knowledge we could gain without this valuable aid to diagnosis. Dr. Trenholme agreed with me that the tumors were not ovarian, but fibroid, and counselled non-interference and the expectant treatment. The relief which our patient experienced when informed that no operation would be required, was very marked. With great care, good nursing and attending to symptoms as they arose, she passed along fairly well until the middle of February, 1883, but on the 26th of that month I found her in great pain, much swollen, feverish, with severe nausea, vomiting and considerable prostration; she had not menstruated but once after I dilated the os uteri, and thought she felt something moving within her, but as she was forty-two years old, and never had been pregnant, I supposed her sensation was due to flatus, and never for a moment suspected that she was pregnant. I satisfied myself, and relieved my patient with appropriate treatment; bismuth and ingluvin were freely used to check the vomiting, and acted like a charm. On 18th March my

attention having been called by my patient to the fact of her having milk in her breasts, the enlargement of the glands, the dark areola around the nipples, the general embonpoint of the woman, the suppression of the menses and her assurance that she felt something moving in her, led to a suspicion that she might be enciente, and a careful examination with the stethoscope detected the sounds of the foetal heart distinctly though feebly, to the right and just below the umbilicus—the double sounds or the “tic tacs” of the foetal heart beating one hundred and thirty while the pulse of the mother was only eighty per minute, was the conclusive and absolutely sure ground on which my diagnosis of pregnancy was made—and the intelligence of the fact, which seemed so impossible a few months before, pleased my patient wonderfully. From this time until the middle of June following, she passed most of her time in bed, fairly comfortable. Some dyspnœa, when she sat up in a chair, considerable swelling of the feet and legs, and the fact that the tumor no longer increased in size, were the only noteworthy features until the 19th June, 1883, when I was called to see her and learned that she had had regular bearing down pains from four o'clock that morning. On examination I found the os dilating and labor fully established, the pains being slow, and her strength equal to the tax upon it. I did not hasten labor further than dilating the rigid os from time to time with my fingers, and at two a.m. on the morning of the 20th of June, I delivered her of a living child, girl, feet presentation, and not one ounce of liquor amnii or blood either before or after delivery; child weighed three and a-half pounds, fully developed and at full term. On attempting to remove the placenta the cord separated from its connection therewith, came away in my hand on the slightest traction, and left the entire after-birth in utero. That which under ordinary circumstances I would not have dared, I was obliged to do as the uterus was inert and quite unable to expel its contents; oiling my arm, I carefully introduced my hand into the womb, seized the placenta which was small but very high up above the umbilicus, and not without some difficulty removed it, at same time taking advantage of the chance, with one hand in the uterus the other on the outside of the abdomen, I ascertained the size, character and position of the tumor. The cavity of the

uterus was very small, just room for my hand to turn round in ; walls very hard and thick ; between my hands I could feel three large, and several small lumps, one on the left side as large as an adult head, the other on the right side, and at the base of the womb, about the size of a child's head at birth, the others smaller. The entire walls of the uterus were excessively hypertrophied, and after birth of child and removal of placenta I could see no appreciable diminution in the size of the abdomen, bandaged, gave mild stimulants and watched with her until seven o'clock, and left mother and child wonderfully well. She made a very good recovery, and in one month was able to move around her house freely.

Friday, 20th March, 1884. Just nine months since her confinement, Mrs. McD. presents the appearance of good health, is strong, able to do house-work, has only an occasional pain and that trifling, and on palpating over the abdomen hardly the slightest trace can be felt—just above the brim of the pelvis—of those terribly painful and rapid growing tumors which eighteen months ago seemed so unlikely of such a cure. Mrs. McD. still nurses her child and has abundance of milk; child is very healthy, weighs fourteen pounds. She still takes the saline and ferruginous mixture which I put her on nearly two years ago.

This has been a deeply interesting case to me, and in hopes that it may not be void of interest to the profession at large, I submit it through the "LANCET," to my medical brethren for the consideration of what I believe are the chief features of importance in it, viz. :—

- I. The rapid growth and intense pain of these fibroid tumors—growth being generally very slow.
- II. The effect of free dilatation of the cervix uteri in the case of sterility at the age of forty-two years, followed immediately after by conception.
- III. The tenacity with which the uterus retained the child during the full term of utero-gestation, while its walls were the seat of such large abdominal growths, and the cavity of the womb so much impinged upon.
- IV. The gratifying result here seen of pregnancy on the diseased tissues of the uterine walls—1st, by arrest of development during utero-gestation, and 2nd, the nearly total absorption of the hypertrophy in the uterus taking place nine month's after child-birth.

TWO CASES OF LAPAROTOMY BY DR. T. GAILLARD THOMAS.

BY A. SANFORD, M.D., BURLINGTON, N. S.

CASE I.—Miss Sarah W., æt. 32, menstruation irregular, duration seven days, scanty, very painful, especially before the flow, and a constant sufferer from pain in the back and legs, and headaches.

Diagnosis.—Anteflexion—prolapsed ovaries.

Treatment.—An incision was made in the median line down to the peritoneum, which was carefully opened with scissors ; the ovaries were readily found and ligatures of carbolized silk were tightly applied. The ovaries were then removed, the cavity carefully sponged out and the wound closed by interrupted wire sutures embracing the peritoneum. The operation was completed in thirteen minutes. The ovaries were found in the condition known as apoplectic or enlarged by blood cysts.

Remarks by Prof. Thomas.—Great care should be used in applying the ligatures ; unless properly done hemorrhage will follow and prove fatal. When searching for the peritoneum, (which in this case was hard to find), if great care is not exercised in opening it the intestine is likely to be wounded, and would prove a terrible calamity to the patient.

CASE II.—Mrs Kattarina A, aged 37, married 15 years, no children nor miscarriages, menstruation regular, amount normal—pain before and during flow, constant pain in the abdomen, back and head. Tumors of two years' growth commencing in the left side, causing vesical irritation and pressure on rectum.

Diagnosis.—Uterine fibroid.

Treatment.—Removal of ovaries—operation same as before, the Prof. explaining the method of applying and knotting the ligature to avoid hemorrhage. The carbolized silk will be absorbed and cause no trouble. When the fibroid came in view Dr. T. remarked that its removal would be a very serious affair and wholly unnecessary, as it would soon atrophy after the cessation of menstruation following the removal of the ovaries. The operation was completed in 11 minutes.

Dr. Thomas is the well-known Prof. of Gynecology in the Coll. Phys. and Surgs., N. Y., and admission to his hospital operations is by sections of

his class in rotation, about ten being admitted at one time. He does not make any point as to the time spent in this operation. Each patient was assigned a cottage, isolated and containing two rooms, one for the patient and one for the nurse. Before the operation these rooms were thoroughly scoured with a disinfectant solution and the patients were briskly rubbed all over with a solution of the bichloride, 1 to 1,000. The operator and his assistants used the same solution upon the arms and hands. No other disinfectants were used during the operations. One of these patients had been taking 96 grs. of sulph. morphia per week.

Of the operations of laparotomy at the N. Y. Woman's Hospital during 1883, there were 80 per cent. of recoveries, some of the fatal cases being desperate at the time of admission.

A NEW EXPLANATION OF THE PROCESS OF INFLAMMATION.

BY PROF. J. PLAYFAIR M'MURRICH, GUELPH, ONT.

In the last number of the *Quarterly Journal of Microscopical Science* there is a translation of Dr. Elias Metschnikoff's paper "On the Mesodermic Phagocytes of certain Vertebrates," originally published in the "*Biologisches Centralblatt*." Metschnikoff has shown elsewhere that certain amœboid cells in the tissues of the invertebrates have the power of ingesting and absorbing food particles. On experimenting with vertebrates, he found that the connective tissue cells had the same power, and that, in a batrachian larva about to metamorphose, the absorption of the tail was brought about by these cells, which he terms "phagocytes." At the beginning of the metamorphosis these amœboid connective-tissue cells collect round the muscles of the tail, and gradually devour their fibres. The fragments of muscle retain their structure for some time after ingestion, so that that process can be readily seen to take place, but gradually lose their stiration and break up into rounded strongly refracting globules.

In order to ascertain whether these "phagocytes" would absorb, and so eliminate from the system, injurious substances, Metschnikoff injected putrescent blood under the skin of a frog, so as to induce septicæmia. In a short time the white blood corpuscles (which are also included in the

term "phagocytes") were seen to contain both still and motile bacteria, and these organisms were especially abundant in the "hæmophagocytes" or white blood-corpuscles of the spleen. This fact, taken together with the probability that the spleen has no very important physiological function, since animals live without much apparent discomfort after its complete excision, seems to indicate a prophylactic function for the spleen, it being merely a protector against septic bodies such as bacteria, the removal of which from the body is its function.

To apply these facts to the process of inflammation. When inflammation was induced in the tail of a newt, the first phenomenon was the collection of connective-tissue "phagocytes" round the injured cells, followed by the passage of "hæmophagocytes" or white blood-corpuscles through the walls of neighbouring capillaries, both collecting apparently for the purpose of devouring and so removing the ruptured, dead and dying cells. In fact the essence of the whole inflammatory process may be said to be a conflict between the "phagocytes" and the septic material, whether the latter be a dead or dying cell, bacteria, or other foreign body. In the invertebrates, where connective-tissue cells are abundant, the vascular system does not participate in the process—only doing so among vertebrates, where the extra-vascular "phagocytes" are not sufficiently numerous to combat the injurious structures, a call for assistance being then given to the "hæmophagocytes." The first effect of irritation is on the connective-tissue "phagocytes," the changes produced in them subsequently influencing the capillary walls, and allowing the transit of the white corpuscles.

The theory has much to recommend it, being founded on logical, *à priori* grounds, and affording simple explanations for many obscure points in connection with inflammation. For instance it affords a simple explanation for the presence of the large numbers of connective-tissue and white blood corpuscles that have been observed in induced keratitis, and also it explains how in certain epidemic fevers—famine-fever for instance—numerous spirilla, etc., can exist in the blood of as yet unaffected individuals, without causing any symptoms of the epidemic. At the same time the theory is quite compatible with all definitely ascertained pathological facts, a circumstance which alone would give it considerable weight.

Correspondence.

COUNTER PRESCRIBING

To the Editor of the CANADA LANCET.

SIR,—The following is a free translation of an article in the *Union Médicale du Canada* for February, and I hope you may not find it unworthy of a corner in your journal.

"Almost every day complaints reach us in reference to the practices of certain druggists, who without hesitation lay aside the spatula and pill-machine, and donning the bonnet of the doctor, write prescriptions, give consultations, etc., and this in the face of the well-known provisions of the Medical Act—provisions which confer on licentiates of the College of Physicians and Surgeons alone the right to practise medicine and to collect fees for their services." "The attempts of Pharmacy to encroach upon the domain of Medicine is not a thing of recent occurrence, nor are we the first or the only ones who have complained of it." "Similar abuses have for many years existed in the United States and in Europe; and in those countries as well as here great difficulty is experienced in devising a proper remedy for their prevention." "In Montreal their increase is becoming more and more serious." "One particular druggist of this city has, to our personal knowledge, a patient abundantly able to pay, actually under his care as his medical adviser, from whom he annually receives a handsome sum, not only for medical but even for surgical services."

"One of our correspondents writes to us that in his quarter there is a druggist who does not scruple to substitute mixtures of his own invention, for those ordered in the prescriptions of the physician; and who sometimes does not give full weight of the medicines ordered (*when they are expensive, I suppose*), although never failing to make his customers pay the full price, just as if the full quantity had been dispensed."

"Another assures us that a druggist in his neighborhood practises medicine to so great an extent that he is obliged to employ a collector to look after his accounts; he draws teeth, opens abscesses, calls himself "Doctor" if you please; and Montreal does not perhaps contain a more *aristocratic gentleman*" (?)

A third correspondent informs us that the clerk

of an apothecary to whom he sends his prescriptions make a specialty of treating gonorrhœa, and that all the diseases of this nature in that locality pass through his hands, and that his business never seems to suffer any diminution. "In short, if the object of druggists be to create this sort of custom, and physicians send their patients there with prescriptions, they can very soon obtain the formulæ of prescriptions for different diseases, although they may not acquire a knowledge of the different methods of treating them."

"An individual presents himself at the counter of a drug store bearing a prescription signed with the name of some popular physician; this excites the curiosity of the druggist and he puts himself upon the alert. A few days after, the same individual presents himself again and requires the prescription renewed. Inquiry is made as to the effects of the remedy, and the response is that it has acted like a charm, and that this is the remedy that has done him the greatest amount of good.

"By means of a number of adroit questions the diagnosis of the physician is ascertained and then the prescription is carefully laid by to serve in its proper time and place.

"In this manner do our druggists educate themselves at our expense in the science and practice of medicine. According to this charming system of giving prescriptions which seems to satisfy us, and by means of which a prescription once given may be filled again as often as the patient or druggist has a mind to, we have nothing to do but sit down (Micawber-like) and wait for something else to turn up.

"Later on we shall return to this subject; for the present we content ourselves with calling the attention of those whose duty it is to interest themselves in such matters to these facts.

"We prosecute to the bitter end quacks and charlatans who do not injure us, it may be, one-tenth part as much as these practising druggists do; and with reference to this matter we think that if there is a law to regulate the practice of physic and surgery, the same law ought to apply to all classes alike."

Such practices as the above are so constant and so glaring in this locality that I cannot but feel in sympathy with my French confrère. It has been no uncommon thing for me to find some prescriptions of mine doing duty for a druggist in effecting

"magical" cures of coughs, gonorrhœa, rheumatism, or some other diseases the diagnoses of which are well known. A great many persons call every druggist "doctor" and calculate on doing their medical business with him, unless when they are so sick as to require the services of the physician at their own houses. Surely the law might be so enforced as to prevent this infringement on the rights of medical men, who pay dearly enough for their few privileges, by long years of study, examinations at college and before the Council, and by the weight of responsibility resting upon them, which in no way affects the standing or the income of the druggist that prescribes from behind the counter.

Yours, etc.,

THOS. R. DUPUIS.

Kingston, April 8, 1884.

Reports of Societies.

TORONTO MEDICAL SOCIETY.

Feb. 28th, 1884.

The President in the chair.

Dr. J. F. Ross read a paper upon the "Wintering of Invalids When, Where, and how to Go." After alluding to various resorts in Italy, France, &c., he said that Southern California possessed most of the requisites of an ideal health resort. Santa Barbara, on the coast of California, presented most of the conditions sought for by the unfortunates. It was situated on a southern slope towards the sea—protected on the north and east from the cold and dry winds from the adjacent desert, with a satisfactory temperature and rain chart, and all the benefits of a refined and wealthy society, and was within easy reach of other resorts, as the Ojai Valley, Los Angeles, S. Gabriel Valley, etc.

Dr. Aikins wished to know what class of cases would be benefited by a residence in high altitudes.

Dr. Nevitt said that Dr. Theo. Williams, had found those cases benefited most by high altitude whose disease was limited, the subjects of hæmorrhage, but not those subject to pyrexia. The chest measurements were generally increased and the area of dulness diminished, emphysema was usually developed, possibly by the greater respiratory exertion induced by the rarefied air.

Dr. Ross presented the stomach of Mrs. D., with the following history:—Mrs. D., æt. 66. Father died suddenly, æt. 77; mother died of paralysis, æt. 86. Two of her sisters are dead, one æt. 7 and one at birth; one sister and four brothers alive and well. Married young; husband died seven months afterwards; had one miscarriage at five months; three years ago had typhoid fever. Until three years ago was apparently well. Twelve months ago was ill with so-called remittent fever. In July, 1883, had a severe chill, pain in bowels, diarrhœa and tympanites, vomiting, anorexia, emaciation; skin became yellowish in colour. Never noticed any abdominal lump until lately. The tongue is red; appetite poor; takes beef tea and oysters without pain or discomfort; no vomiting for several days; some diarrhœa present, passing mucous shreds. Pulse 116; right foot swollen; left foot never swelled; respiration 36; no cough. The *post mortem* disclosed a cancerous enlargement of the lower and posterior portion of the stomach adherent in part to the pancreas; the right kidney was cystic.

Dr. Cameron exhibited a placenta illustrating fatty degeneration, and giving rise to premature delivery. It was very small and presented here and there numerous patches, yellow in colour, hard and resistant to touch, and varying in size from a pea to an almond in the shell. There had been no history of syphilis. Microscopical examination showed fatty degeneration with inflammatory infiltration and organization in parts.

Dr. Macdonald exhibited a placenta. Mrs. A., æt. 22, primipara, menstruated last in September; morning sickness was very troublesome. In December choreic symptoms set in, affecting the right upper extremity especially; but extending to the right leg and foot. The chorea was treated with liq. arsenicalis and oxalate of cerium in two-grain doses with some relief. About four weeks ago the foetal movements ceased to be felt, and afterwards the chorea disappeared. After a very rough drive pains set in, and there was a show, and one week after, delivery took place. Six weeks before delivery she lessened in size. The placenta was small, hardened, and degenerated in spots. There was very little tissue left to carry on the foetal nutrition.

Dr. Cameron considered the spots to be hæmorrhagic.

Dr. Carson thought the oxalate of cerium in the

doses given by Dr. Macdonald would possess little power. He had been in the habit of administering it in ten grain doses.

Dr. Graham related the history of W. L., æt. 45 : Hotel keeper for five years. Seven years ago he gave up hotel life and worked hard on his farm ; never had ague ; was very ill with measles at twenty years of age. Six years ago he had a severe illness. It began by his feeling sleepy, dull and weak. No appetite ; nausea ; took to his bed ; jaundice set in and remained during his illness, a period of three months. He had a burning sensation in the soles of his feet. Before the jaundice set in he was very pale. He gradually recoverd strength and remained fairly well until last March. He then began to feel the same train of symptoms ; sleepiness, dulness, weakness, pallor ; no jaundice. He took to bed on April 25th, and remained there until the latter part of August. He was unable to retain food, much emaciated, constipation very troublesome ; at one time three weeks intervened without a passage from the bowels. His temperature was at or over 102° for weeks. During the latter part of his illness, he took a fancy for buttermilk which he retained on his stomach. Recovery slowly followed. He is now for the third time experiencing a recurrence of the same set of symptoms. A diagnosis of pernicious anæmia was suggested.

Dr. Carson related a case of hæmatemesis which he had treated without styptics. Noticing that she had the pulse of high arterial tension, he had given her bromide of potassium to dilate the capillaries, and gray powder to act on the bowels. On a second occasion nitrite of amyl proved equally efficacious in relieving her.

MICHIGAN STATE BOARD OF HEALTH.

Reported for the LANCET.

The annual meeting of the State Board of Health was held in Lansing, April 8, 1884.

Dr. Vaughan read a paper prepared by Dr. C. P. Pengra, on the "Purification of water by freezing." As a result of a series of elaborate experiments conducted in the University laboratory, Dr. Pengra found, that, contrary to the general impression, freezing does not render water pure. Ordinarily he found less infusoria and bacteria in ice than in the water from which it was frozen, but the ice contained them in numbers sufficient

to preclude its use. In harvesting ice the greatest care should be taken to get it from a pure source.

It was decided to print the names and addresses of the health officers in Michigan, as soon as full returns were received. The number in the State is nearly 1,400. A new edition of the document on the prevention and restriction of scarlet fever was ordered to be printed. It was also decided to publish facts relative to several outbreaks of trichinosis in Michigan.

A resolution was adopted recommending Congress to pass a bill, providing for the prevention of the introduction of infectious diseases into the United States, and for procuring information relating to climatic and other conditions affecting the public.

The Board discussed the merits of several textbooks on physiology and hygiene, with special reference to the effects of alcohol on the human system, and approved for use in the schools Martin's "Human Body," briefer course, second edition, containing special chapters on alcohol and other narcotics ; and Dr. Eli F. Brown's "Alcohol : Its effects on body and mind."

OXFORD MEDICAL ASSOCIATION.

The regular meeting of the Oxford Medical Association was held in Woodstock on the 10th of April, 1884, Dr. A. McLay, President, in the chair ; Dr. A. B. Welford, secretary. Motions of condolence were passed and ordered to be sent to the widows of the late Drs. Coad and James.

The next regular meeting will be held in Ingersoll, on the second Thursday in July.

Selected Articles.

OPERATION IN INTESTINAL OBSTRUCTION.

Dr. Macleod in the *Glasgow Medical Journal* for March, says :—That of the six most important sources of obstruction—viz., intussusception, loops, bands, &c., twists, simple and malignant stricture, and internal strangulation by pouches, the three first are most frequently found in the right groin. Simple stricture is also, in a certain proportion of cases, situated there ; while malignant stricture is far more commonly seated in or below the left groin ; and internal strangulation has no special region where it can, in the majority of cases, be

looked for. The practical bearing of these observations will be apparent shortly. Now, let me very briefly review the different surgical operations which have been, and still to some extent are, practised for the relief of obstruction, and then we will be the better able to understand which of these procedures is best fitted to meet the different kinds of obstruction we have to deal with.

First, the abdomen may be opened in the middle line, or outside of the recti on either side, or a descending coil of bowel may be cut down on wherever it shows itself. The first is, on the whole, the operation which fulfils the indications in many circumstances, as it gives freest access to the whole cavity, and there is less risk of effusion between the muscular walls of the belly, and perhaps affords the best hopes of a rapid recovery. "Laparotomy," as it is now termed, is, however, a very serious and difficult operation in cases of intestinal obstruction. As is well known, it is in no way comparable to opening the belly to remove an ovarian or other growth, as not only are the patients on whom it falls to be performed usually much exhausted by the nature and continuance of their complaint, but the bowel is so much distended that its return within the cavity of the abdomen after the parts have been examined is always most difficult (in truth sometimes almost impossible), while the manipulation which is required to attain this end immensely increases the risks of the operation. The tension, too, which exists after the belly has been closed is so great that all hope of that rest and freedom from irritation, which is essential to the successful treating of such wounds is often destroyed. It is not a little remarkable how, before the belly is opened, in many cases the distension of the bowel may not appear great, and there may be no great prominence of the abdomen; but, so soon as the wall is divided, coil after coil of greatly enlarged and gas-distended gut come out, defying all means of repression or even protection, and causing the utmost dismay as to how best to deal with them. It is always most desirable not to puncture the distended bowel, as however small the instrument employed, there is always considerable fear of fæcal exudation, and ligatures often fail to bring the serous surfaces together so as to close the aperture. The walls of the bowel, too, are thin and weak from the distension to which they have been exposed, and so very serious damage may result. It not unfrequently happens that distinct rupture of the gut will take place where the puncture has been made. In replacing the extruded bowel, take what care we may, it is apt to be bruised and injured, and small extravasations of blood will now and again appear and escape into the cellular connection when pressure is withdrawn. The contact of the finger nail and tips must be carefully avoided, and sponges introduced between the hand and the bowel; but with all this and every care we

can use harm is too sure to follow. There can be little doubt but that it is the manipulation which does such serious harm in laparotomy, and it is probably this which renders the operation so disastrous. In ovariectomy and similar operations we do not, as a rule, require to touch the bowel, and occasionally it is never seen. Further, laparotomy is, in many cases, the only available operation in obstruction occurring in very young and weakly children, yet they are wholly unable to stand so terrible an ordeal.

The cases in which laparotomy is indicated are those in which we have to do with tumours which we desire to excise at the same time that we relieve the obstruction which they occasion; in cases of intussusception, if it is thought possible to disengage the invaginated bowel (that is—early in acute cases if it is to be done at all); in twists also, and in strangulation from internal hernia when we have to adjust the parts, and not merely to save life. It is probably the only operation by which a foreign body obstructing the bowel (not being fæces) can be extracted. In occasional instances in which the exact position of loops, bands, or adhesions can not be recognised, laparotomy may be our wisest proceeding, but of this more will be said. Cancerous tumours, if of small size, and situated in the small bowel, may thus be excised, and the bowel re-united, or a false anus established. If the tumour be in the large bowel, then after excision a false anus may be established in the loin or in the groin, as, it will be in the recollection of the president, I attempted in a patient I saw with him. This is better than attempting to unite that part of the bowel, but in the small gut suturing the divided bowel has most to be said in its favour. It is, of course, only in limited strictures that this operation (colectomy) can be attempted. By such an operation, we attempt not only to remove the obstruction but get quit of the disease. So laparotomy has this strong claim on our attention that it may enable us to carry out a curative, and not simply a palliative treatment.

When laparotomy has to be performed, it is best to make at first a small opening to enable us to search for the seat of obstruction without opening the whole cavity. This must be done with the greatest gentleness; afterwards, if it is found necessary, the orifice may be enlarged. It is the empty bowel which we seek for, and this lies in the pelvis. We trace it up to the place of obstruction. This plan is better and easier to accomplish than to pursue the opposite course, which is what is commonly done. As little bowel as possible should be exposed. A sponge wrung out of carbolic solution should be kept over the hand and wound. We should search first in the neighbourhood of the cæcum, and determine whether the mischief is in the greater or the lesser bowel. The cæcum is the best starting point in all these investigations, and

is a good landmark for our proceedings. If there is a portion of the bowel in a loop, or under a band, or in a pouch, we should draw on the lower or empty part, and this way experience has also shown to be the best way of disengaging an intussusception. If we have to deal with a small band we may break or cut it, but it is better to ligature a broad or large band at two places and divide it between the ligatures, as it is difficult and troublesome to secure any vessel which may bleed. If a foreign body is to be removed the portion of the bowel containing it should be drawn well out of the belly. After the substance has been extracted a false anus may be established by stitching the open gut to the superficial wound, or in favourable circumstances, the bowel may be united by suture. So much for laparotomy. It is, I repeat, an operation not to be undertaken with a light heart, or in any but the most desperate circumstances. There are other methods of operative relief which are much preferable, if they can be used. Of these, colotomy in the right or left loin would, of course, be chosen if we are so able to localise the obstruction as to be sure of opening the bowel above it.

In incurable obstruction seated in the rectum and sigmoid flexure—that is, low down, left lumbar colotomy (or Callisen's operation as it should be called), is the operation which beyond doubt would be employed; but it is sometimes far from easy to be sure that by that operation we can get quite beyond the obstruction even in cases in which we seem to have clear evidence to support that conclusion. The descending colon has been often opened after very careful examination, and the obstruction found to extend above the point opened. That the bowel can be safely and comparatively easily reached in either loin is well established and attempts have been recently made to revive Littre's operation (in which the sigmoid flexure is opened in front through the peritonæum, that is, in the left groin); yet all the difficulties connected with getting beyond the disease are in that operation much enhanced by the near neighbourhood of the disease even when it is confined to the rectum. The necessity of opening the peritoneum in operating will make surgeons slow to substitute an operation which was in former years condemned for its unfavorable results, for one which possesses so many stronger claims to success. If the obstruction lies in the descending colon, left lumbar colotomy (Amussat's operation) is that which should be preferred. No one has yet proposed to re-introduce Fine's operation, in which the transverse colon (which is surrounded by peritoneum) is opened; but in these days of obtrusive and restless innovation there is no saying what may yet arise. It is certain that in an immense proportion of cases of intestinal obstruction, the obstruction lies below the right loin. Bryant gives the proportion 15 to 1.

In the many cases in which the obstruction lies about the caput cæcum and the ilio-cæcal valve, Nélaton's operation (which is an extension and improvement of Pillore's) is beyond doubt the best surgical proceeding. Pillore opened the cæcum, but Nélaton demonstrated how by a very small incision in the right groin that region could be perfectly examined, and how with little risk life could be saved in irremediable cases by opening whatever coil of the bowel (necessarily the distended part, and so above the obstruction) protruded at the wound. The success of this operation has been great, and in the cases where I have myself had recourse to it, it has been most satisfactory in saving life. If the obstruction is such that it cannot be removed, or if the steps necessary for its removal (from the condition of the patient, involves too much risk, this is a most invaluable operation. No blood-vessel need be wounded. The bowel is not much handled or exposed, and an outlet is certainly secured for the imprisoned fæces. It is quite true that in most cases this is only palliative—that is, it does not remove the cause of obstruction in all cases, *but it saves life*. I hold it places the artificial anus at the most satisfactory place—a much better place than in the loin, as it is under the control of the patient, it can be dressed by himself without aid, and an apparatus can be best applied to restrain discharges. Finally, I hold that in the considerable residuum of cases in which we have done our best to determine the seat of obstruction, and have failed, that this right inguinal enterotomy is the right operation to perform.

In conclusion, I would say that, as a rule, if an operation for intestinal obstruction is to be performed, the sooner the better. In acute cases it is a question of hours, and in chronic cases delay beyond a week is inexcusable. Sometimes as in a recent case which I saw with Dr. Hugh Miller, our hand is held by the knowledge that similar attacks in the same patient have, after as long intervals, without interference passed off. But, as a rule, if internal remedies intelligently and perseveringly administered have failed to bring relief, then no good but only evil can come of delay. The using of purgatives should be by the rectum alone; and nourishment, too, as is well known, can be largely administered by the bowel, and it is well that full advantage should be taken of this knowledge. Exhaustion, peritonitis, and perforation are imminent, and the mere hopelessness of the patient will so oppose success that the operation can only lead to disaster. The length of time the obstruction has existed is not so good a criterion in determining whether we should operate, as the violence of the symptoms and, above all, the persistence of the vomiting, which does so much to exhaust the patient. Vomiting, pain, distension, are perhaps the most threatening conditions, and if they continue, are the strongest arguments for operation. If the

obstruction is from some mechanical cause, medicine can be of little aid, and the knife alone be of real service. If the surface is already cold and bedewed with sweat, the face pinched, the pulse weak and intermittent, the belly tender, and the courage gone, we should not interfere. The case is hopeless, and we are too late. Twists, internal hernia, and intussusception in very young children are almost always fatal, do what we like. Bands and chronic strictures are more encouraging, so far as operation goes.

In the preceding remarks I have carefully avoided reference to statistics, though these are abundant; but I have tried to embody the results of their teaching. I have not spoken of the use of the long tube, or of enemata, important and invaluable as these means of treatment in some cases are, because I desire to confine your attention as much as possible to the one point, the "choice of operation in intestinal obstruction." But I may say of the use of enemata in these cases the patient should be laid on the right side with the knees drawn up, and the fluid injected through the tube as it is passed, so as to facilitate its entrance. I would also desire to express in the most emphatic manner my conviction that, in cases of intestinal obstruction, purgatives kill many persons—if not by intensifying and aggravating their condition before the operation is performed, certainly afterwards by the violent action of the bowel to which they give rise after it is set free. The well-known rule of administering no solid food and only opium, and as little liquid as possible by the mouth should be strictly adhered to.

True it is that not a few cases of intestinal obstruction which seem altogether hopeless recover by the unaided powers of nature, and in some of these instances we cannot tell what was the cause which gave rise to the stoppage even after it has passed away. But, alas! these rare cases of recovery are too often allowed to warp our judgment and cause us to stand aside and abstain from interfering when an operation alone can be of any use. The great mortality which has attended operations for obstruction has had a pernicious influence upon surgical practice. We hesitate in the face of such terrible statistics of failure as past practice has recorded. But it may be that it is chiefly in this delay that the danger lies, and that bolder action might be the means of averting complications in these most unfortunate and anxious cases.

FREQUENT AND PAINFUL URINATION.

The following clinic is by Prof J. C. Skene, of Brooklyn (*Med. News.*):

Gentlemen:—To-day I desire to call your attention to frequent and painful urination arising from certain disturbances and anatomical lesions of the sexual organs.

Case 1.—Our first patient is thirty years of age, and has now been married eight months. Her health has always been fairly good until two months ago, when she began to suffer from frequent and painful urination. These annoying symptoms have continued ever since, and have also increased in severity. She states that in the morning and during the forenoon she is comparatively comfortable, and can retain her urine a reasonable length of time; but towards the afternoon the desire to urinate is frequent and urgent, and she has much pain in evacuating the bladder. These symptoms continue until night, and during the early part of the night she is compelled to rise several times and relieve her bladder; but after she has once fallen asleep she remains quiet until awaking in the morning at her usual time for rising.

Now the fact that she is able while asleep, to retain her urine until the bladder is distended to an average capacity, is an indication that the trouble does not involve the entire bladder, but that it is limited to the urethra, and, perhaps, the neck of the bladder. If she has a general cystitis the probabilities are that she would not be able to hold even an average quantity of water in the bladder at any time. We cannot, however, be sure as to the extent to which the bladder is involved without an examination of the urine, but it is fair to suppose, judging from her symptoms, that the trouble is limited to the urethra, and probably the neck of the bladder to a slight extent. It is a curious fact in her history that during the forenoon she is comparatively comfortable, but that her symptoms become aggravated in the afternoon, and continue during the early part of the night. This may be due to one of two causes.

First.—It may be due to the fact that the irritation subsides after lying in bed for a time, and does not return until she has been about for several hours during the early part of the day. The fact of her being upon her feet and maintaining the erect position, naturally brings more pressure to bear upon the neck of the bladder, and would thus aggravate an already existing irritation, and give rise to frequent urination, which continues until she again seeks relief by resuming a recumbent position in bed for a time. This certainly is one of the causes for this frequent urination in the later part of the day.

Secondly.—There is a cause which gives rise to the same peculiarity of clinical history, and that is *malarial poisoning*. A patient suffering from malaria quite frequently has irritability of the bladder indicated by frequent and painful urination, these symptoms being always most marked in the afternoon and evening. In this case, however, there is no indication of malarial trouble; so that the peculiarity of her history is no doubt due to the erect position maintained during the early part of the day.

Regarding the primary cause of her trouble, that

is not quite so clear ; there is no history of gonorrhœal inflammation which could have affected the urethra or bladder, as it sometimes does ; neither has she any uterine or pelvic disease which would directly or indirectly affect her bladder. It is barely possible that it arises from the change in her social relations ; having married late in life—some eight months ago—it is just possible that her family relations may have produced an irritation of the urethra and base of the bladder which, when once established, is very liable to persist if not relieved by treatment. Having an opportunity of examining this patient's urethra and the neck of the bladder, the probability is that we shall find a hyperæmic condition and perhaps some tendency to ulceration of these parts, but of that we cannot speak positively, as the examination has not yet been made, nor shall we trouble her with such examination until we see if we can relieve her by treatment.

In the treatment of this case we will render the urine as bland and non-irritating as possible, by permitting her to drink freely of the alkaline mineral waters—Vichy for instance—and in case she cannot procure that, we will order the acetate of potash. At the same time I will give her a favorite prescription in these cases : R. Fl. ex. buchu, ʒ ij ; tinct. conii, ʒ j. Sig. ʒ j half an hour before meals.

If this fail to give her relief, we will then employ injections of sulphate of zinc, half a grain to the ounce of water, with the addition of a drachm of the fluid extract of hydrastis canadensis. In using this local application, we will employ a syringe with rather a large nozzle, which is to be introduced just within the meatus, then slowly and carefully inject the mixture so as to force it along the urethra into the bladder ; being careful to have the bladder emptied previously. By adopting this plan we are sure of bringing the remedy in contact with the entire mucous membrane of the urethra. We will also request her to abstain from coition, as that may be the cause of her trouble.

Case 2.—I have here a very interesting case brought to me by Dr. Stewart. This lady is forty-five years of age, unmarried. She gives us the following history : Up to six weeks ago she menstruated regularly every four weeks ; since four weeks ago she has menstruated three times, she is therefore suffering from menorrhagia. She has great pain in the back and suprapubic region, with frequent and painful urination ; altogether, suffering extremely, she says. I am now making but very little pressure upon the abdomen, and yet she complains very much. Upon examination I find an extremely interesting pathological condition here. Now bear in mind the prominent symptoms ; there are intense backache and pain in the suprapubic region with an abnormal condition of the menstruation and a frequent desire to urinate. Dr. Stewart, in carefully examining the condition of the

sexual organs discovered conditions which did not altogether coincide with her history as given by herself. He found the uterus large and well developed, with an os externum which looked as if it had seen service ; the same also of the perineum. Upon being questioned very closely, or, as they say in law practice, "cross-examined," she admitted that she had had a child five years ago, and had been also operated on for amenorrhœa.

This gives us a clue to the cause of the present condition of things which we have here. We find the uterus is large and the fundus is pointing towards the upper part of the symphysis pubis, the os looking towards the hollow of the sacrum, the body of the uterus is therefore pressing upon the bladder and crowding it downward—a condition which is sufficient to account for this frequent urination. The uterus is anteverted, and the symptom is the functional disturbance of the bladder, due, no doubt to the displacement. I here show you a specimen of her urine. We often have symptoms of cystitis being established. In this case we have vesical tenesmus because of the pressure of the fundus uteri. A normal bladder will tolerate pressure for a time, but after a while it will incite this frequent urination ; it is therefore a question whether or not we have cystitis here. You will observe in this urine that there is an abundant deposit of the phosphates ; if this clear up upon the application of heat, and we find no products of inflammation under the microscope, we will simply say that this is a mechanical derangement of function.

There is, however, another unfortunate condition here, and that is, that while the uterus is anteverted, it remains there in spite of all our efforts to restore it. It is anteverted and fixed in this position because of a former peritonitis. If she has been subjected to an operation for the relief of amenorrhœa, she has been in the way of having pelvic cellulitis or peritonitis, or both, and the evidence is that she has had one or both.

We have here, then, an incurable anteversion ; all that we can do is to relieve the symptoms ; we cannot remove the cause of her pain, backache, and vesical tenesmus ; we can only modify these while hoping that she will live long enough to pass the menopause and be relieved by the final involution of the uterus. The plan of treatment will be to try and relieve her general condition. This urine shows her nervous system to be below par ; when we have this brick-dust deposit, it is said to be a symptom that the waste of the tissues is in excess of the assimilation for their support. It is said of clergymen that the deposit of phosphates in the urine is greater upon Monday than any other day in the week, by reason of the using up of the nerve force on the preceding Sunday. It is possible that we may improve this woman's general health so that her system will be able to tolerate

her local difficulty, and thus bear her suffering much better.

It is impossible to use a pessary in this case as the uterus is fixed; part of her vesical irritation may be due to the fact that there are adhesions of the bladder, so that now it is impossible for that organ fully to distend. The peritonitis has probably extended in front of the broad ligaments forming adhesions, and thus holds the bladder in a splint so that it cannot extend; this may be another cause of her frequent urination. So that we have here two factors; the displaced uterus, and the thickening of the peritoneum upon the walls of the bladder which prevent its distension. We can do little but apply the douche and paint the vaginal roof with iodine; we can also introduce a balladonna suppository if advisable. This, however, as I have told you, can only be palliative.

This case is an exceedingly important one, as those who are most prone to this condition are those who abuse the generative functions.

There is one thing more here which, however, hardly comes under my Chair. We find above the umbilicus a marked pulsation which may be an aneurism of the aorta, and which might possibly account for some of the abdominal pains.

Case 3.—Our next case is also one of incontinence of the urine; the cause, however, of this condition in this patient is entirely different from that of the preceding ones, and therefore must not be arranged under the same head. The patient, however, comes to us suffering from this incontinence, and I now present her to you as illustrating another cause of this difficulty. This little girl is twelve years of age. When she was three years old she had an attack of scarlet fever, and has never been well since; she has not accomplished much in the way of growth or development; she looks somewhat anæmic. During the night she has to get up six or seven times to pass her water, and, unless exceedingly tired, the desire always awakens her. During the day the passing of water is equally, or more frequent; for this reason she has been unable to attend school. This is very interesting, as it illustrates a class of cases which you will meet quite frequently. When urinating there is always pain, and she informs me that, if she attempts to restrain herself, it increases the pain; but immediately upon evacuating the bladder there is complete relief for a time. For the last nine years this has been going on. It is, however, a rare thing as a rule in this difficulty for the patient to awaken at night, the urine being generally passed in bed. This is a most miserable condition for a child to be in, been obliged to get up to urinate many times every night, or else to sleep in a bed saturated with urine.

Acute cystitis often follows the eruptive fevers, and sometimes in these cases it becomes chronic, as in this case, so that we should always be on our guard in the eruptive fevers and see to it if there is

any cystitis following, otherwise the result will be the same as in this case. Now, whether the child has general cystitis or an inflammation of the neck of the bladder with urethritis remains to be seen. The way to make the diagnosis is repeatedly to examine the urine, selecting the last drachm or two which passed, and if it contains pus and epithelium we may be tolerably sure that there is general cystitis. The order of the development of the pathological conditions in this case is as follows; first, scarlet fever, which gave rise to acute cystitis, or urethritis, which in place of ending in recovery, ran into the chronic or continuing variety.

CATARRHAL JAUNDICE AND CHRONIC BRIGHT'S DISEASE.

CLINIC BY PROF. BARTHOLOW.

The case of jaundice before you is one which you have seen before. An attack of jaundice rather persistent, as this one has been, and occurring in a man at this period of life, is by no means a small matter, and would be looked on with solicitude by any practical physician.

Let me state what has been the result of treatment. The patient tells us that he has gained two pounds during the past two weeks. The jaundice has disappeared, and the symptoms depending on it have passed away. The stools are natural in color and the deep coloration of the urine no longer exists. He, however, has some itching of the skin. This is due to senile changes in the skin, especially in the terminal portion of the nerves, the end organs.

In this case phosphate of sodium has been used persistently, and after a time the chloride of gold and sodium were added. I have repeatedly called your attention to the remarkable value of these two remedies in this affection, namely catarrhal jaundice.

There is another point I may mention before dismissing the patient. No case of catarrhal jaundice is without importance. It has been shown by experiment, and by clinical observations, that if there is any obstacle to the outflow of the bile for any length of time, the liver undergoes structural change. Hyperplasia of the connective tissue first occurs, then follows contraction. This is not the spirit or the drinker's liver, but it is allied to that condition, although the change is not so marked. Hence, I conclude that no case of catarrhal jaundice is without importance, for the longer it continues, the greater is the danger of hyperplasia of the connective tissue and permanent structural changes.

I have brought the case before you to show what can be done by appropriate remedies, and the persistent and faithful use of such remedies.

This young man had an attack of gonorrhœa

two years ago, which was followed by cystitis. This finally led to a complication on the part of the kidneys, and he probably had what is commonly termed surgical kidney. The occurrence of the renal complication was announced by the presence of albumen in the urine. He now has albuminuria, and the legs and feet are somewhat œdematous. The hands also look puffy, although there is no distinct œdema. The general appearance of the patient is good. One who has had albuminuria for a year usually presents an appearance of anæmia, which does not exist in this case. On examining the urine, we find a large percentage (10 per cent.) of albumen, and at times the proportion is probably greater.

The symptoms are not limited to those which I have mentioned. Examination of the eye reveals white spots in the retina, the evidence of albuminuric retinitis. There are also cardiac changes. The action of the heart is strongly heaving. The changes in the peripheral arteries which belong to this malady are also found. There is hypertrophy of the heart, which causes the strong, heaving impulse, and there is high tension in the arteries, due to the hypertrophic condition of the muscular layer of the arteries.

You have often seen these cases, and I shall not go further into the morbid changes, but I want to say something in reference to the treatment. These cases are readily diagnosed, but the difficulty is in the treatment. We now have at our command some remedies which exert a remarkable effect upon this malady. The first of these is nitro-glycerine. Its introduction has given quite a different complexion to the treatment of these cases. This remedy is employed in the form of the centesimal solution; one minim of nitro-glycerine dissolved in one hundred minims of alcohol. One minim of this one per cent. solution is the beginning dose. This may appear to you an extremely minute dose, but try a few minims of this preparation and see if your respect for the activity of this drug is not increased. In some persons the action of the heart is accelerated and the face flushed by a single minim, while others may take from five to fifty minims. I had, a short time ago, a patient who could take eighty minims of this solution, not only without injury, but with decided benefit. This was a case of spasmodic difficulty of breathing. In albuminuria, I have found that the dose readily borne by an adult is from one to five drops, the average probably being three drops. You should begin with the smallest dose, and gradually increase until the characteristic symptoms are produced. It is necessary to produce these characteristic physiological effects in order to obtain the best results. I cannot too strongly insist on that proposition. Unless these effects are produced, curative results cannot be expected. It is fortunate that these effects can be obtained without any injury to the

patient, provided the remedy is used in anything like the proper dose. It is perfectly safe within these limits.

Why do we give nitro-glycerine? We should always have a reason for the faith that is in us. For the effect which nitro-glycerine has on the circulation and its secondary effect upon the structure of the kidney. Nitro-glycerine produces marked dilatation of the peripheral vessels. This at once takes away the blood from the important large vessels and central organs, and distributes it to the periphery. Of course, when the arteries are suddenly dilated, the work to be done by the heart is reduced, and it can send the blood on the round of the circulation with less force. Nitro-glycerine in this way relieves the heart and lowers the high tension which belongs to this malady. Secondly, it opens the way to the relief of a condition that had hitherto not been relieved by any measure which he had under our command.

I have, however, another reason for my faith; that is, practical experience. It has been demonstrated that this remedy has a remarkable influence, and that the amount of albumen progressively diminishes under its use. The extent of improvement depends upon the amount of damage which the kidneys have suffered. We cannot restore lost parts. We cannot put new structure into the kidney, any more than we can restore a finger that has been amputated. If we wish to accomplish good, we must begin early. There is no time to be lost in this case. I shall begin with the administration of minimum doses of the centesimal solution of nitro-glycerine, four times a day, and gradually increase the dose until the patient feels the characteristic flushing of the face and other symptoms produced by this remedy.

Have we any other remedy? The drug to which I have just now alluded as potent in preventing hypertrophy of the connective tissue of the liver, is equally potent in preventing hypertrophy of the connective tissue of the kidney. The result to be secured is exactly the same. In addition to this reason for the use of chloride of gold and sodium, I can again quote experience. I have seen remarkably good results from the exhibition of this remedy in these cases. The dose is one-twentieth of a grain three times a day.

In addition to this, the bowels should be kept in good condition by the use of a weak saline water, the function of the skin is to be kept active by the use of warm clothing, and the patient should carefully guard against changes of temperature.

There is another remedy which is also a food, that is skim-milk. The patient should live largely upon this, which acts as a diuretic as well as a food. As a rule, he should avoid solid food, living almost exclusively on a liquid diet. As he improves, the amount of solid food may be increased. These hygienic measures are of the greatest importance,

for without them it is hopeless to expect a favorable result from any method of treatment. — *Col. and Clin. Record.*

EXCISION OF THE ANKLE.

Dr. F. Lange, of New York, presented before the New York Surgical Society, Feb. 26th, 1884, (*N. Y. Med. Jour.*) six patients in whom he had excised the ankle joint more or less extensively within the last two years. In five of these cases the operation was done for scrofulous disease. The patients were at the time of the operation from one and a half to nine years old. In one case a gunshot injury gave the indication; the patient was eighteen years old. He said, I shall omit to ventilate the question, how far there is the indication to excise the ankle joint for scrofulous disease. Certainly a great difference of opinion exists regarding this point. A good many surgeons, especially in England and America, are in favor of expectative treatment. During six years of living in New York, I have not seen a single excision of the ankle joint except one, which, strictly taken, was no excision; nor have I heard of one; and I am perfectly aware that in children a great deal can be achieved by mere expectative treatment. On the other hand, I hope to prove by my cases that very good results can be reached by excision, that the disease in some cases is undoubtedly shortened by years, and in one or the other may have saved the limb. The prejudice prevailing against excision is mostly based, I believe, on deficient knowledge of good after-treatment, and in some degree on inattention to the technique. To these two points I shall principally direct your attention.

Regarding the operative procedure, I do not offer anything new. The genius of Langenbeck has presented a method which, in spite of all new, more or less sensational modifications, is by far the best in every respect. It causes the least injury, gives the best guarantee for new formation of bone, if that can altogether be expected, and allows of sufficient insight over the field of operation. To make the operation still more strictly subperiosteal, I remove the periosteum, in all those places where ligaments or tendons are attached, by means of a chisel. In small children, where the epiphysis is mostly cartilaginous, free use can be made of the knife. The bones are removed by means of a sharp chisel also; eventually a cross-cut is made through the periosteum of the tibia below the line of intended separation, to obviate tension and to allow of free access for the chisel. In this way also superfluous denudation of the bone is avoided. The chisel must be sharp and thin, and form, by means of numerous small cuts, a smooth perpendicular surface on the cross-cut of the bone remaining—to be sure, at the expense of the specimen.

I always unite the periosteum-cylinders by a few cat-gut sutures. In all cases the fibula has been excised also. In the traumatic case the astragalus was left untouched, in one case only its articular surface has been removed, in four it has been removed entirely. In one case complete *evidement* of the os calcis was added. I need not say that antiseptic principles, with the permanent antiseptic dressing, decide the wound treatment. The limb is suspended by a long, anterior plaster-of-Paris splint, after the manner of Beely, into which iron rings are fastened. It reaches as far as the middle of the thigh, and keeps the knee in a somewhat flexed position.

Great care must be taken during the wound dressing to keep the foot in such a way that it is not too much pulled forward. The assistant who holds the foot is very apt to commit this blunder. In this way the axis of the bones of the leg falls behind the intended point of the new joint, and you will see in some of my cases that I have not been entirely able to overcome this deficiency. In cases where the whole astragalus has been removed that might not be any disadvantage, because the bones of the leg are then supported by a part of the os calcis which is lying more toward the middle line of the foot and transfers more of the weight of the body upon the heel. In this way, I presume, the formation of pes valgus later on is avoided with more certainty. Where, however, the astragalus is left, the correct relation of the axis of the leg must be strictly observed. It is good to support the thigh and calf during the wound dressing, and to advise the person who holds the foot to fix it more by tender manipulation and slight extension than to contribute anything to raising the limb.

After the wounds are healed, which can be achieved usually under a few dressings, within, let us say, from six to eight weeks (in some of our cases it was four weeks; in one, the most extensive, the wound is not entirely healed after almost five months), the patient gets a light dressing of paste-board and starch bandages, or silicate, with quite thin wooden splints interposed. This dressing goes upward to the middle third of the thigh, and reaches down to the toes, keeping the knee slightly bent. It is split anteriorly, and can be removed and reapplied by means of straps and buckles. I should advise cutting out the region of the heel to such an extent that, for reasons mentioned above, the foot can be slightly pushed backward within the dressing. I extend this dressing above the knee in order to avoid rotation of the leg within the dressing.

Now comes a very important stage of the after-treatment, during which, by means of active and passive movements, electricity, and bathing, the muscular action is stimulated. For this purpose the dressing is often removed and exercise done

while the patient is in the lying posture, the limb being raised as much as possible. By and by the child is made to push away a hand, which offers a slight resistance. In this way the young parts are accustomed to pressure, and after some weeks they will be so far advanced that, with the dressing, which must fit very accurately, and allow only of a slight weight being thrown upon the foot, they commence to walk. The parents must be inspired with the importance of devoting all their attention to these exercises. After several more weeks (in four of my cases in about two months after the operation) the patient gets a good-fitting double splint, which is inserted in a strong laced shoe, allows of a movement of about twenty degrees in the region of the ankle joint, and reaches as high as the head of the tibia. Here it ends in two side-pieces, which form the upper part of a pretty strong leather cylinder. The latter must be adapted very well to the upper half of the leg as far down as the lower edge of the calf. If the patient has sufficient means, it is good to furnish every lateral splint with a mechanism by which the distance between the condyles and the sole can be increased. This can be used very well to correct abnormal pronation or supination. To improve an abnormal dislocation of the foot forward, pass an elastic ribbon across the lateral steel splints, which presses slightly against the posterior surface of the lower end of the tibia and fibula. The apparatuses will probably have to be worn for years. So far I have not deemed it advisable to remove the splint in any one of the children, though in one the operation was done almost two years ago. Four of these children run about all day, and one would hardly suppose that they had undergone such extensive operations.

RUPTURE OF THE BLADDER—RECOVERY.

Dr. Weir reports the following case in the *N. Y. Med. Record*, March 29th:—An Italian laborer, aged twenty-eight years, was admitted to the New York Hospital, November 20, 1883, having been injured a short time previously by a bank of earth falling on him while engaged in making an excavation for a gas-pipe in the street near by. The accident occurred about ten o'clock in the morning, and on enquiry it was ascertained that he had had no alcoholic drink that day, and had urinated not long before the receipt of his injury. The mass of earth that fell upon him struck most heavily on his pelvis and left hip. When he was admitted no shock existed and his general condition was excellent. There was noticed a slight ecchymosis of the scrotum and a spot of blood at the meatus urinarius. This fact led the house surgeon to pass a rubber catheter, which gave exit to a moderate amount of bloody urine which became clearer as it flowed. Palpation over the

supra-pubic region gave rise to a little pain; considerable tenderness was felt over the left hip, but no evidences of pelvic fracture were obtained.

The patient passing urine with some difficulty and at times bloody, the catheter was passed during the next twenty-four hours three times. General condition good, though increased tenderness was then experienced in the hypogastrium.

November 22d.—The injury had been considered until to-day as a slight urethral laceration, but the marked increase in the supra-pubic dulness, which now extended four inches above the pubis and across into each groin, with tenderness, led to a closer examination of the patient. The catheter was passed readily into the bladder and only occasionally gave exit to blood-stained urine. The urine itself was passed at times voluntarily, and was not apparently diminished in amount. The temperature was but 99°. Abdomen not distended though its walls above the dulness somewhat rigid. Condition still good. No signs of fracture elicited, but the finger in the rectum detected a softer spot on the left side of the prostate which was decidedly painful. The ecchymosis of the scrotum and perineum was now very pronounced.

November 24th.—The temperature had risen to above 100°, pulse 104°, and patient began to be restless and disposed to vomit. Tympanites increasing, with abdominal tenderness not only above line of dulness but below it. A large hypodermic needle inserted in the hypogastrium drew out some bloody fluid with an acid reaction and urinous odor. Nothing distinctive could be felt in the rectum. The patient was etherized, and an incision, under sublimate irrigation, 1 to 1,000, was made three and one-half inches long in median line, midway between symphysis and umbilicus, until the subperitoneal cellular plane was reached, where a large cavity, containing at least a pint of bloody, undecomposed urine, was found. The finger could be carried its full length behind the symphysis, but nothing was detected. To effect a more complete diagnosis, as well as to allow of the carrying, if possible, of a drainage-tube from the hypogastric opening down and out of the perineum, the patient was placed in the lithotomy position, and on a staff introduced into the bladder a median incision was made, opening the urethra just anterior to the prostate. The finger passed in here toward the bladder revealed a rent running along the left side of the roof of the prostate which was lost in the wall of the bladder itself. Its upper limit was not defined, purposely, to avoid extra damage to the parts so favorable as they already were. Through the supra-pubic incision a large silver catheter was carried, and, aided by the finger in the perineal wound, was caused to pass through the laceration of the bladder and emerge from the lower wound. To the eye of this catheter a thread was attached, and a large rubber drainage-tube

pulled through as the silver instrument was withdrawn. Each end of the tube was secured by a suture to the skin, and a second drainage tube was then passed into the bladder, and its external end also fastened in the perineum. The cavity of the extravasation and the bladder were carefully washed out with a warm sublimate solution of 1 to 2,000, and iodoform gauze placed over each wound, though so lightly that urine could readily flow through the dressing.

The progress of the case was in every way most satisfactory, as is shown in the following notes from the case-book of the hospital. Dressing re-applied at 7 p.m.; temperature, 100°; all urine escapes through tube.

November 25th.—Condition improved, little pain; temperature, 101° all day; dressings changed and tubes irrigated.

November 28th.—Patient doing well; temperature still elevated (100°). Tube in bladder removed on 27th; urine passed by the other tube, which has been shortened daily from the perineal end.

December 2d.—Temperature normal; urine is still forced through tube into abdominal incision; tube removed from this opening and placed in perineum.

December 5th.—Patient himself removed tube from perineum last night, and much pain followed, replaced this morning; it drains thoroughly; cavity washed out daily with sublimate solution.

December 9th.—Patient removed tube last night and it could not be replaced; urine voided by the penis with little pain.

December 24th.—Wound in perineum closed; wound in abdomen only a linear ulcer. Allowed to go out of the hospital to-day.

OBSTRUCTION OF THE ABDOMINAL LYMPHATIC GLANDS.

BY ROBERTS BARTHOLOW M.D., ETC., PHILADELPHIA.

The first case which I bring before you is one presenting many points of interest, but its diagnosis is by no means clear. There are certain objective symptoms, however, which are very patent. For over two years this young man has had the swelling of the inferior extremities which you see. This swelling does not pit on pressure, in the ordinary way. There is some depression on pressure, but it is not ordinary pitting. The skin and subcutaneous areolar tissue are thick and firm, and the swelling does not present the ordinary characteristics of simple oedema. There is, besides the swelling, a change in the subcutaneous connective tissue—a change allied to that which takes place in the peculiar affection called myxœdema. This disease, which has lately been described, is characterized by a mucoid degeneration of the subcuta-

neous connective tissue, and is connected with atrophy of the thyroid gland. This change is, as a rule, especially well marked about the face. This malady was first described by Sir William Gull, of London, and was entitled by him a cretinoid state. It occurs most frequently in women, but it is also met with in men.

I do not mean to affirm that this is a case of myxœdema, but I desire to impress upon you the fact that there is a change in the connective tissue which allies this case with myxœdema. No renal disease, no cardiac affection, no oedema of the cellular tissue could give rise to this condition.

It is a curious fact that myxœdema has been found to be associated with atrophy of the thyroid gland. The effect of extirpation of this gland has lately been studied, and it has been found that subsequent to the surgical extirpation of the thyroid gland, a change analogous to that which we see in this patient takes place.

There is another peculiarity which at once attracted my attention when examining this patient, *i.e.*, that on the slightest pressure the skin assumes a distinctly red hue. When I draw my finger across the abdomen a well marked red line is left, and the slightest excitement, emotion or exertion causes him to get very red. In other words, the capillaries of the skin are in a condition of dilatation. There is a paralytic state of the vaso-motor system with which the circulation in the capillaries is concerned.

It is a perfectly well known fact that when there is obstructive disease of the capillary lymphatics, a change like this occurs in the connective tissue. This at once suggested that there might be some condition of obstruction of the lymphatics of the lower extremities.

What has caused obstruction in these lymphatics? The patient tells us that he has attacks of what he calls intermittent fever, during which the glands in the groin become enlarged and red, and painful lines extend down the thighs. This throws some light upon the affection. There are temporary attacks of obstruction of the lymphatics of the inferior extremities. This is very evident at certain periods. There is also a permanent obstruction, which has existed for two years; what has caused this?

The abdomen is full, more so than is usual. Even when the lungs are completely emptied, the abdomen remains full, so that I cannot, either by touch or percussion, demonstrate the existence of any enlarged body in the abdominal cavity; but taking the symptoms in connection with the history, I have no doubt that there is disease of the intra-abdominal lymphatics, causing obstruction in the lymph channels of the limb and swelling.

I have already stated that the circulation is peculiar. There is paresis of the vaso-motor system, which is shown by the state of the skin after exer-

tion, excitement or pressure. Has this any relation to the condition of the lower limbs? I think it has. What can be the origin of this condition of the capillaries? There is no cardiac affection, and the solution of the difficulty is probably found in intra-abdominal pressure on the sympathetic, so that it produces this obstruction of the lymphatic circulation below; it also causes the paresis of the vaso-motor system. I admit that this is not a very certain diagnosis. The problem is very obscure and the terms of the problem are somewhat uncertain, but taking it all in all, such is my explanation of the phenomena.

What is the treatment? Assuming that the diagnosis just announced is correct, what is the therapeutic diagnosis? The problem is, how shall we get rid of these enlarged lymphatic glands within the abdomen? What remedial measures can we employ to diminish their size, to change their character, to restore the lymphatic circulation of the limb and remove this enlargement? There are certain remedies which do undoubtedly affect the lymphatics; mercury is one. Iodine and the iodides are other remedies which have the same effect. Manganese and iron, under certain circumstances, also act on the lymphatics. We can at once dismiss the last two, for the appearance of the patient does not indicate the need of iron. This brings us to remedies such as mercury and the iodides, which have a selective action on the lymphatic system. I shall give this patient twenty grains of iodide of potassium three times a day, and also one-twentieth of a grain of bichloride of mercury, with one grain of extract of cinchona, three times a day, in the form of a pill. As you see, I do not give the iodide and mercury together. I direct a simple solution of the iodide to be made and the patient to take twenty grains in four ounces of water, three times a day, before meals, so as to secure its diffusion through the system before the mercury is administered. I think that it is always an error to combine these two remedies, for in such a combination you do not, as is commonly supposed, obtain the beneficial effect of both drugs. In the course of two weeks we should see some results from this treatment.—*Col. and Clin. Record.*

TREATMENT OF ACUTE ABSCESS.

BY STEPHEN SMITH, M.D., NEW YORK.

In many instances of the ordinary acute abscess, I have recently had excellent results in treating them for immediate cure. The following example illustrates the course pursued:

A man had an abscess on the external part of the thigh, resulting from a severe fall. There had been a high grade of inflammation, much suffering, and a temperature of 103°. At the time of the operation the temperature was 101. There was

fluctuation, but the pus was not very near the surface. The treatment was as follows: When the patient was fully under the influence of the anæsthetic, the parts were thoroughly washed with soap and water and a flesh brush, and then with a douche of corrosive sublimate solution 1 to 500. Then the abscess was opened with a knife, treated with a carbolic solution 1 to 30, the opening being of a size to admit the nozzle of a Davidson syringe. The depth of the abscess cavity was two inches. The pus was forced out by pressure, and when it ceased to flow the nozzle of the syringe, well disinfected, was introduced and the edges of the wound held firmly around it. The cavity was then distended to its fullest capacity, with corrosive sublimate solution 1 to 5000, the amount of water injected being one pint. Withdrawing the syringe tube, the solution was forced out, with strong and gentle pressure. This injection, and hyperdistension was repeated three times, when the water flowed away quite undischored. An incision was then made down to the cavity of the abscess, its full length, the incision being six inches long. With tenacula the edges of the wound were held apart, and the entire cavity exposed. During this part of the operation the irrigation with the corrosive sublimate solution, 1 to 2,000, was continued. The internal surface of the abscess was covered with large granulations and shreds of broken down connective tissue. The process of cleansing the wound was next begun, with disinfected hands and instruments. All the shreds of tissue were carefully dissected away, and the granulations were gently scraped off with the curette, until a perfectly clean surface was everywhere apparent. Several small vessels were ligated with carbolized ligatures, and the whole surface of the cavity thoroughly irrigated. The wound was closed with the interrupted suture, except at the lower extremity, where a small opening was left for drainage, over which was placed a disinfected sponge to absorb the discharge. The external wound and adjacent skin were sprinkled with iodoform; folds of gauze, between which iodoform was sprinkled, were applied around the limb from below the knee to the hip; over these layers, a dressing of borated cotton was wrapped about the leg and thigh; and over this was applied a light plaster of Paris dressing, which completed the operation. On the following day the temperature had fallen to normal, and did not rise again to 100, the pain entirely ceased; the appetite returned; sleep was sound and undisturbed. The patient stated that from his recovery from the anæsthetic he had felt entirely well. The dressing was removed on the eighth day. The wound was entirely closed, and though there was some thickening of the tissues involved in the injury, there was no tenderness. He could walk without pain or inconvenience, and there was a rapid subsidence of the swelling of the part.

It is safe to estimate that this man saved at least a month in time by the operation. What was saved in pain, impaired health, and possible dangerous sequelæ, cannot be estimated. I have operated for acute abscesses of the neck, back, groin, etc., in a similar manner, and have not failed of rapid and complete recovery without further symptoms.

This operation may be extended to furuncles and carbuncles when they have a local origin. The exciting cause is some small necrosed tissue. If this irritant is early and thoroughly removed, and the parts rendered aseptic, the disease will be arrested. Carbuncle of the face, the so-called malignant pustule, has long been treated, and generally the disease is arrested, by early incision, filling the wound with spirits of turpentine. The value of this treatment was supposed to lie in the local suppuration induced, but it is more probable that the turpentine acted as an antiseptic. If the surgeon would go a step further, and not only make a free incision through the inflamed tissues, but carefully scrape off, as far as possible, all diseased structures, and render aseptic the surfaces of the wound by the remedies now found so efficient, the disease could doubtless be arrested in its incipient stage.

We are evidently on the eve of the adoption of measures for the *prevention* of this formation of pus in a great number of cases where hitherto the practice has been to encourage suppuration as the proper method of cure. Indeed, there is little doubt that the time is at hand when the very presence of pus in the practice of surgery will be evidence of the inefficient use of remedial measures.—*The Esculapian*.

THE TREATMENT OF PILES BY INJECTIONS.

Dr. Wm. H. Veatch, of Carthage, Ill., who has had considerable experience with this method of treating piles (*Peoria Med. Monthly*) gives the following answers to a number of questions addressed to him by correspondents desiring explicit instruction regarding the operation :

I confine myself to two principal modes of examination. 1st. The knee-breast position of the patient, placed on a table two by six feet, well cushioned. My stand is taken on the left side of the patient. Pressing the nates apart will reveal any external tumors which exist ; or the finger may be introduced through the sphincter ani to explore for internal tumors. 2nd. I place the patient on the table, on left side, the limbs flexed on the body, the right limb being drawn higher than the left, with the knee resting on the table ; then make the examination as before.

Piles originate from a common cause ; *i. e.*, ob-

struction of the hemorrhoidal veins, therefore they are of the same nature and may be cured by the same treatment. The ordinary hypodermic syringe of Tiemann & Co. is the one I have always used.

The management of the needle is an easy matter when your patient is in proper position and the tumors properly exposed. Use due caution in filling the syringe ; see that no air is left in the barrel ; insinuate the needle gently into the tumor at any point from which you can most easily reach the sac, or center of the tumor. I have sometimes thought I have had better results from depositing the remedy at the base of the tumors, but in so doing I am aware that I risk depositing the fluid in the cellular tissue beyond the hemorrhoidal tumor, or in an unobstructed vessel beyond the limits of the tumor. In such an event I can easily see how we might realize Dr. Allen's fears of embolism. The safest plan, therefore, is to pierce the tumor at its apex or centre.

I have used all strengths, from equal parts of carbolic acid and water to that of only five per cent. of acid, and have had good results from all ; but as a rule I use a twenty five per cent solution. Patients will bear this strength as a rule without complaining. I have used tr. iodine, sol. subsulph. ferri, tr. ferri chlor., sol. plumbi acetat., sol. zinci sulph. and simple cold water ; anything that will coagulate the blood. Several of the above act more promptly in that way than carbolic acid, but my experience is in favor of the acid on account of the readiness with which absorption takes place after its use. A little alcohol thrown into the tumor after the coagulum has formed will assist absorption.

The following is the formula I employ : ℞ Acidi carbolici ; glycerini, aa fl ʒ j. ; morphinæ sulph. gr. viij. ; aquæ dest., fl ʒ ij. M. Sig. Inject from five to ten drops into each tumor once in two weeks.

In nervous persons, who are easily hurt, and complain of very slight causes of pain, I inject but one at a time, but frequently I inject all at once if there are half a dozen.

External tumors are always much more painful under the operation, and are much longer in being absorbed. Occasionally tumors suppurate and discharge considerable quantities of pus, just as they frequently do without an operation of any kind ; but these pus sacs usually granulate and heal with but little difficulty.

I give great latitude in regard to the time necessary to a cure. They have run all the way from five days to five months. A great deal depends on the length of time the tumors have existed.

When the tumor is once cured the vein at that point is obliterated and cannot fill again ; but obliterating the vein at one point will not prevent a tumor from forming in any other part of the vein. The length of time which patients suffer after

treatment depends in a great degree on the condition of the patient, and the strength of the solutions used. Ordinarily the first twelve hours puts an end to the pain, *i. e.*, the pain consequent upon the treatment.

The finger and the eye are all the instruments necessary for an examination of any case. A two-valve speculum, a tenaculum and scissors, a camel's hair pencil and a sponge are all the instruments you will require, besides your syringe, to treat any case of true hemorrhoids.

I can now call to mind only two cases who went to bed in consequence of the treatment. Almost all say that the pain of treatment is not to be compared to the pain they have suffered during the inflammatory stage of the recently filled tumors.

These are answers to the principal questions I have been able to cull from the mass of letters I have received, and I have to regret that my space will not allow me to enter more fully into the discussion of the various topics represented by my correspondence.

Now I will say to one and all, that the disease is to be treated as all other diseases must be, by the expenditure of a good proportion of common sense, and if one does not understand it he had better keep hands off. Always remember Prof. Andrews' admonition :

"This or any other plan is not exempt from danger when practised by ignorant men."

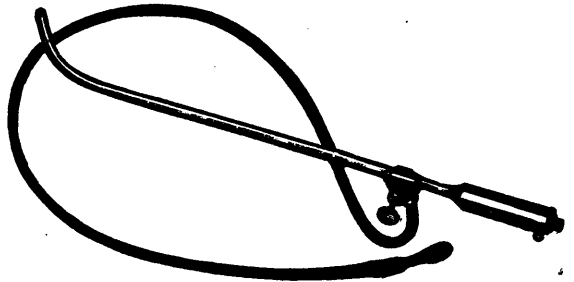
First, understand the nature of the parts diseased. Second, understand the disease you are attempting to cure. Third, understand the nature of the remedy you are making use of ; and fourth, understand how to apply it. With these simple rules in view one can scarcely do harm.

ORDINARY STONE SEARCHER.

Professor Andrews, of Chicago, gives the following description of this instrument in the *Four. Am. Med. Association* for March :—The first step towards an instrumental demonstration of the presence of a stone is by the process of sounding. This operation, as performed with the old instruments, was sufficient to detect stones of ordinary size ; but in cases of very small calculi, or in searching for the last minute fragments during the operation of litholapaxy a more delicate apparatus is required. To meet this necessity I devised in the year 1877 an attachment to the ordinary searcher, by which I was enabled to detect by the ear the smallest bit of calculous matter. The apparatus was shown to the Illinois State Medical Society in 1878, and figured and described in the Society's Transactions of the same year (p. 254). In the form there depicted the instrument consists of a light, hollow searcher, having a small rubber tube and ear piece attached. The searcher being introduced into the

bladder, and the ear piece placed in the surgeon's ear, the slightest contact with sand or grit becomes distinctly audible. Having subsequently discovered that a solid searcher transmits the sound as well as a hollow one, I modified the plan and appended a small clamp screw to the rubber tube, by which I could attach it at pleasure to any metallic sound whatever.

The Figure shows the apparatus clamped to Sir Henry Thompson's searcher. I have one with two tubes attached for the purpose of increasing the intensity of sound by the binaural effect, as well as to assist clinical instruction by enabling two students to listen to the sound at once.

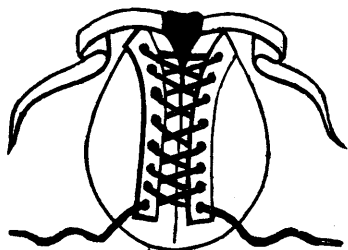


The search of the bladder, to be thorough, must be made with at least two forms of instruments, viz. : the ordinary searcher with a short beak, which can be rotated backward to explore the *cul-de-sac* behind the prostate, and the one with a very long beak to reach the front of the bladder near the pubis. I often clamp the tube to a simple britannia metal sound capable of being successively bent into several different curves as the case may require. Contrary to one's natural supposition, this soft metal conveys sound almost as well as steel. The auditory sounds are manufactured and sold by E. H. Sargent & Co., of Chicago, to whose enterprise and kindness I am indebted in the construction of many other new forms of apparatus made at my request.

I have practiced for some years another innovation, which I consider of still more importance, though I am unable to say whether I have any priority over others in that respect. I refer to the great value of using warm carbolized water during the whole operation of litholapaxy, both to distend the bladder during the crushing, and to wash out the fragments afterward. Carbolized water acts as a decided local anæsthetic, benumbing the nervous activity of the bladder, and seeming to me to greatly lessen the shock of prolonged operations ; besides, it checks bleeding, and leaves the viscus in a thoroughly antiseptic condition, preventing the formation and the putrefaction of pus, and acting as a very powerful local antiphlogistic. I use it in the strength of about 1½ per cent., and am satisfied that it greatly lessens the danger of all operations in the bladder.

A SUBSTITUTE FOR STRAPPING THE TESTICLE AND THE TREATMENT OF HYDROCELE.

Dr. J. C. Warren has devised a chamois-leather bag for the purpose of exerting pressure on a small collection of fluid left in the tunica vaginalis remaining after an operation for radical cure. The bag can easily be applied by isolating that portion of the scrotum containing the testicle to be compressed and forming a pedicle, which is preserved by tightening the chamois-leather string. The bag is then laced from above downwards, and, if it has been made to fit snugly, exercises a gentle and equable pressure. If it is necessary to increase



the pressure a few turns of a common narrow roller bandage around the equator of the globular mass are all that is necessary. This bag is free from the well-known discomforts of plaster, is easily made and applied, and can be removed and re-applied by the patient himself as often as is desirable, thus avoiding excoriation at constricting points. In the single case in which it was used the effusion promptly disappeared, and has not since returned at an interval of nine months.

Dr. Warren spoke of the advantages of Dr. Levis' method of treating hydrocele by the injection of one drachm of the liquefied crystals of carbolic acid. It appears to be specially adapted to the lighter forms of the disease, is almost painless, and produces very moderate reaction, so that the private patients he had operated upon on a Saturday were able to be about again on the following Monday. In but one case had he found any perceptible discoloration of the urine, although this symptom of carbolic absorption had been carefully looked for in all his cases. He recommended the substitution of the ordinary horse subcutaneous syringe, with a trocar attachment to one of the needles, instead of the ordinary trocar and Sims' ear syringe which Dr. Levis uses. In large hydroceles of long standing the acid does not produce any perceptible effect upon the disease. He spoke of the discomforts and comparatively long confinement attending the operation by incision, even under the most careful antiseptic precautions, as laid down by Volkman. The constitutional disturbance and the local œdema, with occasionally sloughing of the connective tissue, even when the

wound has been kept aseptic, make this an operation which should be reserved for those cases only which are not amenable to other modes of treatment.

Dr. Strong spoke of the difficulty of keeping a Lister dressing on the scrotum after operation. There is always less danger of œdema when the scrotum is kept raised.

Dr. Gavin, in injecting hydroceles, uses Delano's rubber bulb syringe, as being more convenient than the cylinder syringe.

Dr. Marcy had had abscess and sloughing follow the injection of a drachm of liquefied carbolic acid crystals. One half that amount has been found to be equally effectual in curing the hydrocele, and is not accompanied by so great danger of excessive inflammation.

Dr. Cheever never attempts a radical cure in old men, but advises them to be content with tapplings repeated as often as necessary, as a low form of inflammatory œdema of the scrotum, ending in death, is described as peculiar to the aged.—*Boston Med. Journal.*

A CONSULTATION.

An only child, within whose tender life
Centre the fondest hopes of husband, wife
And many friends, seems on the verge of death ;
Convulsed with pain ; with fitful, rapid breath,
Clenched hands, eyes sunken, nostrils stretching wide
He scarce can count the pulse's hasty stride—
He looks at his thermometer amazed,
Its column to a frightful figure raised ;
Ah, you and I have felt this anxious fear,
And wished some able counsellor were near
To aid in such extremity, or bear
Of such responsibility a share.
No time to lose, he summons to his aid
His nearest rival ; time is quickly made,
And Jehu-like, with foaming steed he drives,
And at the moment specified arrives.
In manner brusque, pompous in air and style
He greets his brother with the blandest smile,
With new-found friends shakes hands with relish keen ;
Happy to see them, happier to be seen.
His conversation he directs to these,
With studied effort to attract and please ;
Tells of an anxious case he had last night,
Which by his skill is coming out all right ;
Details his treatment in a learned way,
Bold and heroic as we sometimes say ;
Consults his watch, and softly names the time
When he must see a case with Dr. Prime,
A city lady, wealthy and refined,
Attractive both in person and in mind.
His fine impressions made, he condescends
To interview the doctor and the friends ;
And, ere he sees the case, states his belief
That he can soon suggest a prompt relief.
He quickly scans the case, and feigns to see
At once the lesion and remedy ;
Tells of a dozen cases he has had
Within a year with symptoms quite as bad.
And thus the farce of consultation ends ;
What further he discloses to the friends
We ne'er shall know ; but somehow it transpires,
He gets the case—his brother soon retires.

—Dr. Nye, Cincinnati *Med. Journal.*

TO ASCERTAIN THE COURSE OF THE SMALL BOWEL IN ABDOMINAL SECTION.—It is confessedly difficult to distinguish the upper from the lower end of a knuckle of small intestine presenting at an abdominal wound; yet it is often desirable to know this, *e.g.*, when practicing abdominal section for the relief of internal intestinal obstruction, or in attempting duodenostomy, so called. Operators have ere this passed some feet of intestine through their hands, uncertain as to whether they were proceeding upwards or downwards in the direction of the tube.

The jejunum and ileum, loosely moored to the spine by the mesentery, are the districts of the bowel usually in question. The mesentery, at its border, follows the windings of this portion of the gut, and is correspondingly complex; but, on approaching the spine, it rapidly narrows, until, at its attachment along the front of the column, its root is but about six inches in extent. This attachment of the root, extending, it will be remembered, from the left side of the body of the second lumbar vertebra to the right sacro-iliac synchondrosis, follows roughly the middle line of the body, its two surfaces facing nearly right and left.

The relation of the bowel to the root of the mesentery furnishes a sure guide to the direction of the bowel; for, if the piece of bowel which presents at the abdominal wound be held in a line with the body, and the bowel be in its true direction—*i.e.*, the apparently upper end be really so—the hand, passed along the side of the bowel and backwards towards the spine, will be guided by the mesentery—if this last be held out taut from the spine—to the same side of the spinal column. Thus, passed to the right side of the bowel, the hand will be conducted by the mesentery to the right side of the column; to its left side, if passed to the left of the bowel. Here at the mesenteric root, the hand may be passed upwards and downwards, without hindrance, along its attachment. But, should the apparently upper end not be really so, the hand passed to the right of the bowel, will be guided by the mesentery over the left side of the spine; passed to the left of it, it will be guided over to the right side. In explanation, we may look upon the mesentery as a partition dividing the abdominal cavity into two compartments, having a simple arrangement of right and left posteriorly at the spine, but complexly arranged towards the free intestinal border.

The above method has been tried, always with correct results, by several of my friends, and by myself, when making post mortem examinations. It seems to me to be worthy of trial on the living, and will, I hope, in some cases, clear away doubt.—*British Med. Journal.*

THE TREATMENT OF ABSCESSSES OF THE NECK.—Dr. John A. Lidell, in a very instructive article

on this subject in a number of *The American Jour. of the Medical Sciences (Med. Record)*, points out that sudden death may occur from deep-seated abscesses of the neck, or the continuance of life may be greatly endangered, much oftener than is generally supposed; and that these abscesses in the neck are more frequently attended with hemorrhages due to the opening of important blood vessels by ulceration or erosion, and by *ramollissement* consequent upon the disorders themselves, then abscesses in other surgical regions. The superior liability of cervical abscesses to the spontaneous occurrence of dangerous hemorrhages arises in part from the greater number and importance of the cervical blood vessels; but more particularly from the inaction and exhaustion, or low state of the constitutional powers, and consequent feebleness of the reparative forces, which rapidly result from most of the deep abscesses of the neck, or rather from the inability to swallow enough food to support life, and from the powerlessness to get any refreshing sleep, or even repose, with which these abscesses are oftentimes attended. The septic or toxæmic influence of the fetid secretions and exudations which present themselves in the aural and faucial cavities, in many instances, also aids materially to still further depress the patient, and weaken the reparative process of his system. These deep seated abscesses of the neck, when allowed to run their own course, do not exhibit any tendency to a spontaneous cure; but, on the contrary, they always tend to destroy life by burrowing or spreading, etc.; and Dr. Lidell shows that the earlier they are laid open and evacuated the better for both patient and surgeon. As soon as fluctuation is discerned, the abscess cavity should, without delay, be freely laid open, the coagula turned out, the bleeding point, or source of the hemorrhage, brought distinctly into view, and the delinquent vessel itself should be ligatured on each side of the aperture in its walls. But should the ligatures cut through, the actual cautery must be applied to the bleeding point, the primitive carotid artery should be firmly compressed against the cervical vertebræ by the surgeon's thumb or fingers applied on the anterior part of the corresponding side of the neck, between the larynx or trachea and the inner border of the sterno-cleido-mastoid muscle, with force enough to press the artery backward and inward against these vertebræ, and flatten it thereon. Should this procedure fail, it will be advisable, especially in cases where the bleeding proceeds from tonsillary abscesses, to ligature at once the primitive carotid artery.

ALUM IN WHOOPING-COUGH.—Dr. H. Cullimore, M.D. (*Brit. Med. Journal*), says:—This is a very old and efficient remedy in many parts of the world, as well with the profession as the public. It was the first I ever used, and still, after a fair trial of most drugs, I like it best. It may be given

immediately after the cessation of the catarrhal stage, for which small doses of aconite answer best; in fact, as soon as ever the distinctive cough has appeared. I generally give it as follows, though at the same time I should like to say that the belladonna is not necessary:

R. Aluminis sulph. gr. ii ;
Tincturæ belladonnæ m iii to v ;
Tinct. cinchonæ m xii ;
Syrupi aurantii ʒ ss ;
Aquam ad ʒ ii. M.

This is given three or four times a day for a child of four years. This mixture has a rough bitter-sweetish taste, and is much relished by children. It also answers well (without belladonna) in convalescence from broncho pneumonia attended with head-sweating and loss of appetite.

The *modus operandi* of alum is not so clear. Dr. Meigs gives a drachm in honey every ten minutes in croup till the child vomits, and in this disease prefers it to all other remedies; and it may possibly be by some action short of emesis that it acts in whooping-cough. I have, however, myself never given it in such doses (which could not be long continued), and am inclined to attribute its utility to its astringent, bracing, and tonic action on the blood and on the mucous membranes of the stomach and air-passages.

Whooping-cough proves fatal in most cases by sub-acute catarrhal bronchitis—a condition which small doses of alum are eminently calculated to prevent and restore.

It is possible, also, from its antiputrefactive properties, that it may exercise some deleterious influence on the *materies morbi*, or what I may perhaps call the germs of the disease. However this may be, alum is an excellent remedy. In the combination above given, I have almost invariably found it to lessen the cough, increase the appetite, strengthen the child, and in the end cure the disease.

Sometimes, however, a hacking spasmodic cough preventing sleep, which no drug seems to relieve, occurs. Here, one or two teaspoonfuls of brandy, or less according to age, with a double or fourth part of hot water and very little sugar, answers remarkably well.

FORCED RESPIRATION IN PHTHISIS.—Dr. J. Solis Cohen has been favored by his friend, Dr. John C. Berry, of Okayama, with the following summary of an article on Forced Respiration, by Dr. Kashimura Seitoku, of Tokiyo, from the *Koi Geppo*:

Reference is first made to the prevalence of the disease in Japan (twenty-four per cent. of all the deaths being due to consumption of the lungs); on the importance of treating the disease early ("beneficial effects only following early treatment") and the uselessness of much of the treatment now

generally advised. "Creasote, benzoate of soda, salicylate of soda, etc., are all quite useless," "while cod liver oil and malt, iron and malt, and tonics generally, are of little or no use."

"The plan I propose requires no medicines, no apparatus, no money, no physician, no nurse." * * * "It is simply to observe forced respiration twice daily, breathing about one hundred times at each exercise, and compressing and expanding the chest walls, after the method of Gerhart. During this exercise, the arm corresponding to the sound lung should be pressed against its side, while that corresponding to the side of the diseased lung should be extended high above the head during respiration, and lowered and pressed firmly against the side and front of the chest during expiration."

"Instead of the above, the author first adopted the plan of having the patient swing heavy weights, but as this frequently gave rise to hemorrhage it was abandoned for the more moderate and efficient exercise above referred to. The swinging of weights, however, is thought to possess advantages, if not too vigorously observed."

"In contraction of the lung from pleuritis, the position in sleep should be on the *well* side—the diseased lung thus being placed uppermost in order to admit the air freely."

Two illustrative cases are then given.—*Philadelphia Polyclinic*.

DEEP AND RAPID BREATHING.—Breathe deeply and rapidly for two or three minutes and you will be surprised how long you can "hold your breath" without even wishing to breathe. This is probably the secret of the "man-fish" who frequently exhibits himself in museums, etc. His feat is to remain under water an astonishing length of time.

The composition of nitrous oxide (laughing gas) is the same as common air, except that it has a larger proportion of oxygen; and its anæsthetic effect is thought to be due to its oxygen. Deep and rapid breathing, by supplying an excess of oxygen to the blood, has been found to be an anæsthetic of considerable value. Many operations rendered painless by this measure have been reported. We wish to suggest that this forcible "ingestion" (oxygen is a gaseous food) may be made a valuable therapeutic procedure. Habitual deep breathing will doubtless benefit many cases of anæsmia, malnutrition, etc., provided that the air be pure. Indeed, we can scarcely imagine any abnormal condition that might not be benefited in this way. Those persons who lie awake at night and toss about restlessly, vainly trying to go to sleep, will find deep and rapid breathing for several minutes to be a sweet and grateful com-poser.

Forced feeding has recently been very successful in the treatment of nervous and other maladies.

SURGICAL FOLLIES.—The *Med. Age* gives the following abstract of a paper read by Dr. J. B. Roberts, Philadelphia, before the Westchester Medical Society, and published in the *Polyclinic*. He points out what he considers to be follies in connection with surgical procedures. He calls them the ether folly, the incision folly, the sponge folly, the styptic folly, the suture folly, the adhesive plaster folly, the dose folly, etc.

The ether folly is almost universal. It consists in allowing the inhalation of atmospheric air with the vapor of the ether, as it is proper to do when giving chloroform. In giving ether the napkin holding it should not be removed from the patient's nose and mouth. When it is necessary to replenish the anæsthetic the corner of the napkin should be turned up and a fluid ounce of the ether dashed upon it, or it may be poured on the outside of the napkin and covered with a large dry towel. The pure ether vapor must alone be inhaled to secure its best effects. The only exception to this rule is when blueness and congestion of the face occur as a result of spasm of the respiratory muscles. Usually one deep inspiration will be sufficient to relieve this, when the napkin should be immediately replaced. Squibb's ether is in no way superior to that of other reputable manufacturers.

The incision folly consists in making a cramped cutaneous incision, instead of one sufficiently large to fully display the tissues needing examination. A cut of the skin three inches long is no more dangerous than one two inches long. In opening abscesses a free cut is more satisfactory than the mere puncture or button-hole incision.

The sponge folly consists in the employment of sponges which have done previous service. They are seldom or never properly free from septic matter. To obviate this danger napkins or towels are to be employed instead of sponges. Japanese paper napkins answer a very useful purpose. Absorbent cotton is valuable but it is expensive, and besides it is apt to leave filaments entangled in the wound.

The styptic folly is also a very common one. Alum, tannin, and that vilest of all styptics, Monsel's solution, prevent or delay union by first intention by irritating the edges of the wound and preventing their coaption. Except when a large vessel is severed pressure is all that is demanded. When such a vessel is divided ligation, torsion or acupressure should be employed, but under no circumstances styptics.

The suture folly. The old idea that sutures should not be employed in the scalp has been long exploded, but still another folly exists in connection with sutures, and that is that silver wire only should be employed for suturing purposes. Iron wire is equally valuable and much less expensive. A nice iron wire can be bought for five cents a spool. If it becomes a little rusty, it can be rubbed

clean in a moment, should the operator object to the presence of a small amount of oxide of iron in the wound.

The adhesive plaster folly is prevalent. The enveloping of a stump or the covering up of an incision with adhesive plaster prevents drainage, is uncleanly and does no good. Adhesive plaster has little or no value in surgery, except for making extension, and preventing motion in cases of fracture.

Sponges, styptics, and silver wire are useless and worse than useless, and their banishment will be a long stride in the progress of surgery.

The dose folly consists in the exhibition of an insufficient quantity of medicine. It should more properly be called the *small dose* folly. Of what use is a sixteenth or an eighth of a grain of morphia to a man in severe pain? Give him a quarter or even a half grain, and repeat if necessary. And what is true of morphia is true of all other drugs—quinine, atropia, strychnine, digitalis, mercury, pilocarpine, etc.—they must be given with a bold hand to produce their effect. First, be sure of your diagnosis and then go ahead. Many surgeons fail to cure because of the tentative use of drugs which comes of uncertainty of diagnosis.

Another surgical folly is the local use of nitrate of silver for the intended destruction of a virus or for the disintegration and removal of fungous or malignant tissue. Nitrate of silver, though popularly called "caustic" is not a caustic; it is a mere irritant, scarcely more active than tincture of iodine. The caustics to be used by surgeons for the purposes mentioned are chromic, nitric, carbolic and acetic acids, potassa and similar active drugs and the hot iron. Under many circumstances the best *caustic* is a sharp scalpel.

NITRITE OF AMYL IN URÆMIC ASTHMA.—Dr. S. C. Smith, of Halifax, in the *Brit. Med. Jour.*, June, 1883, p. 1115, in referring to the usefulness of nitrite of amyl in allaying the paroxysms of uræmic asthma, says that in its very power lies its danger; for it often gives such relief, even in desperate conditions, that a feeling of false security is apt to be engendered, and thus, instead of the asthma being accepted as a most urgent warning of danger, the facility of getting relief is taken as a permission to throw aside restraint. The author points out that there are several kinds of dyspnoea but only in one group of cases does nitrite of amyl produce any relief, and those are attacks of cardiac dyspnoea, due to failure of the heart; in these cases the seriousness of the attack is often overlooked, and the ease so rapidly obtained should not be taken as proving the neurotic origin of the attack, the case being really one of failing heart; hypertrophy has done what it can, and is no longer able to overcome spasm of the arterioles. A warning ought to be taken, so that a life free

from worry and excitement may be lived by the patient, with careful attention to diet and regular habits, and the steady employment of small doses of iron and digitalis.—*The London Med. Record.*

BLISTER FOR COUGH.—Prof. James Tyson, M.D., of the University of Pennsylvania, in the *Medical Times*, says: The very best medicine, and often the only one which will accomplish the result, is a blister. We have now in our wards a case of consumption in which the cough was most troublesome for six or eight weeks, and cough medicines of all kinds had failed; but in twenty-four hours the symptom was relieved by a blister.

[Better than the blister, is this:

R Morph. acetat.....gr. iij;
Acidi hydrocy. dil..... $\frac{3}{4}$ j;
Syr. tolut..... $\frac{3}{4}$ iij.

M. Ft. sol. S. A teaspoonful as often as cough demands.

The medicine should be kept in a dark bottle well stoppered. Some cases will require more and some less morphia and prussic acid, but this is a benign remedy. The blister and croton oil are well for pain, but should be a last resort for cough. Where mucous secretion is deficient, iodide of potassium is the remedy. Where strength to raise the sputa is deficient, ammonia, alcohol, and coffee are the remedies.]—*Louisville Med. News.*

COMPOUND FRACTURE OF THE HUMERUS INVOLVING THE SHOULDER JOINT.—Dr. L. A. Stimson, (*New York Surg. Soc.*) presented a man, thirty-five years of age, who fell two stories, striking his arm, while on the way down, upon a railing, and producing a compound fracture of the upper end of the humerus, communicating largely with the shoulder joint, the wound extending from the coracoid process across the upper part of the arm. The wound was washed with a bichloride solution, one to two thousand, partly closed by sutures, two drainage-tubes were inserted, and anti-septic gauze was applied. The interest in the case was confined to the plaster dressing which was used. It was a combination of plaster dressing upon the arm and a plaster jacket upon the body, united by three iron cross-pieces, which held them so firmly that the patient could be moved or turned in any direction without producing pain. Rapid recovery took place with a movable joint.—*N. Y. Med. Four.*

EXTIRPATION OF CANCEROUS UTERUS.—Dr. A. Reeves Jackson (*Gynecolog. Trans.*) summarizes an investigation of this subject by the following propositions:

1. Diagnosis of uterine cancer cannot be made sufficiently early to insure its complete removal by extirpation of the uterus.

2. When the diagnosis can be established, there is no reasonable hope for a radical cure; and other

methods of treatment far less dangerous than excision of the entire organ are equally effectual in ameliorating suffering, retarding the progress of the disease, and prolonging life.

3. Extirpation of the cancerous uterus is a highly dangerous operation, and neither lessens suffering—except in those whom it kills—nor gives reasonable promise of permanent cure in those who recover. Hence it fails in all the essentials of a beneficial operative procedure, and should not be adopted in modern surgery.

DICTIONARY OF SURGERY.—Mr. Christopher Heath has undertaken to edit for Messrs. Smith & Elder, a "Dictionary of Practical Surgery," on the lines of Quain's Dictionary of Medicine, which has scored such a satisfactory success. The new dictionary is to be a compendium of the practice of surgery of the present day, readily available for reference by the busy practitioner, and it is hoped that it will be published within two years from now. The articles will be signed and will be expressed as concisely as possible, historical details being omitted, the question of pathology only discussed when absolutely necessary. The profession will look forward with great interest to the publication of this work, which is much wanted, and which will no doubt fully come up to the expectations which all who know its editor will have formed of it.—*Med. Times and Gazette.*

THE DRY MOUTH OF THE LITHOMIST.—At a recent clinic, Prof. Brinton said that an attendant of lithotomy is dryness of the surgeon's mouth, similar to that produced by belladonna; and Prof. S. D. Gross remarked: "It is peculiar to the operation for stone; I have often felt it." A thesis showing the relation of a stone in one man's bladder to the salivary glands in another man's mouth would probably take the Lea prize.—*Col. and Clinical Record.*

HOPE'S MIXTURE.—This mixture is one commonly employed in the Southern States for simple diarrhoea.

R—Aqua camphoræ, $\frac{3}{4}$ iv.
Tinct. opii, gtt. xl.
Acid nitricum, gtt. iv.—M.

SIG.—Tablespoonful every three hours.—*Med. Student.*

COUGH MIXTURE.—

R—Ammon. mur., $\frac{3}{4}$ ij.
Morph. sulph., gr. j.
Tr. aconit. rad., ℥ xvj.
Ext. belladon., fl. ℥ v.
Ext. glycyrrh., $\frac{3}{4}$ j.
Syr. tolut., $\frac{3}{4}$ j.
Aq. ad., $\frac{3}{4}$ iv.—M.

SIG.— $\frac{3}{4}$ j. every three or four hours.

THE CANADA LANCET.

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Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

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COMPARATIVE DURATION OF LIFE.

Mortality tables are now so full, complex and accurate as to deserve to be ranked as a science. Several circumstances have combined to bring about this degree of perfection, the principal of which are the needs of insurance companies. Capital is ever wide-awake, and wherever we find countless millions engaged in fierce competition, we may rest assured, that neither money nor labor will be spared to explore the particular field of operations. The vast and growing interests of life insurance, and the keen competition which has grown up of late years, demand the fullest possible information regarding the duration of life, under all the phases and conditions of modern civilization. Governments also are important contributors to this statistical fund. Sanitarians too have borne a conspicuous part in the work. The net result is, that man's life from the cradle to the grave is mapped out, defined and tabulated with such mathematical precision as almost to make life and money convertible terms. Even a superficial examination of the tables reveals some queer and interesting facts. We shall not proceed far in our study of them before we see the bottom dropping out of some cherished idea, and discover the wide difference between facts and fancies.

The preservation of life being nature's first law, it is pleasing to learn that the average age of man is on the increase. During the last half century the duration of life in England has advanced seven per cent. There is great reason for believing that another half century will add at least seven per

cent. more. From this it would appear that man, in some measure at least, presides over the external conditions which conspire to cut short his earthly pilgrimage. Here we naturally recall the words of Scripture, "There is an appointed time for man upon earth," and that interpretation of these words which attaches a fatal fixity to the duration of human life. The hackneyed phrase, "His time was come," is often used to condone neglect on the part of relatives, or to cover the retreat of the physician, but it is more often used to express belief in a determinate limit to man's time upon earth.

That mortality is decreasing, and longevity becoming more and more assured, are great and pleasing facts, whatever may be the cause of final dissolution, whether the accidental pressure of external causes, want of physical organic harmony, or a predestined purpose. It is perfectly plain that the food we eat, the clothes we wear, the houses we live in, the air we breathe, and the life we lead, are all elements of life or death, according as they are good or bad. If not, then, vain indeed, is all medical and sanitary improvements, and in vain have the wheels of science been revolving all these weary years. Let us rejoice that disease is no longer regarded as a special and mysterious providence. Men of all shades of opinion now regard it as a thing very largely preventible, and in no small measure subject to human control. Superstition and dusty dogmas die hard, but they must yield before the glare of universal knowledge. Health and life, and not disease and death, are what mankind ardently wish for. The process of dying stands correlated to the process of living, yet the impulse to ward off death is so strong, that life is the first law of our nature.

"'Tis life whereof our nerves are scant,
Oh, life not death, for which we pant!
More life and fuller that we want."

After the general fact that the duration of life is increasing, perhaps the next most interesting information gathered from mortality tables, relates to the view we get of the beginning and end of life. Viewing one end of the bridge of life as pictured by Addison in the Vision of Mirza—a bridge in the midst of the 'tide, having three score and ten arches, with several broken arches, making a total of about one hundred—viewing this bridge at one end we see it covered with mil-

lions of children, among whom are more boys than girls. Extending our vision to the other end we behold a handful of aged people, the number of women exceeding that of the men. This latter fact, woman's longevity exceeding man's, is one of the things that never would occur to an ordinary mind. We regard woman as the weaker vessel, exposed to the trying ordeals of maternity, the victim of many fatal diseases from which men are exempted, and needing and receiving man's love and tenderest care. This fact is all the more surprising when we remember that the males start out with a surplusage of nearly ten per cent., even though half of this is lost before life is really begun, the number of still-born males greatly exceeding that of females. The first five years show a male mortality of 7.216 per 1000 to 6.016 of the females. During the first ten years 46½ per cent. of all born pass off the stage. During this period boys suffer greater mortality than girls. The period between ten and twenty years, we are told, is the only period in which there is an excess of female mortality. This is the period of sexual development and excitement. Between fifteen and twenty, females are peculiarly exposed to phthisis. Between twenty and forty is the highest period of mortality in adult life, in both sexes; it is also the period of child-bearing, and the time when we would naturally look for an excess of female over male mortality, but the figures actually show the reverse of this. At the close of this period, namely, between 35 and 40, Finlayson shows that out of 100,000 persons there will die 7042 males and 6959 females, and between 40 and 45, Ostend says the numbers are 11,107 males and 7,094 females. Marriage increases the duration of life of women. The mortality resulting from child-bearing, Tarnier puts as low as one-third of one per cent. The climacteric period, contrary to general belief, is not attended with unusual mortality. The "change of life" produces functional derangements, we know, but the belief that women are more liable at this period to be attacked by fatal diseases is clearly and fully contradicted. On arriving at the farther end of the bridge, we still find women numerically stronger. The number of women who live to over 80 are about as 2 to 1 compared with men. The statistical tables of New York for ten years, among deaths of centenarians, give seventy-two females and nineteen

males. Women's dangers in child-bearing are more than counterbalanced by the injuries to which man finds himself exposed in the pursuit of his daily avocation. How woman manages to remain "to hold the fort" after her lord and master has made his exit, affords food for further reflection.

MEDICAL ASSOCIATION MEETINGS.

The association meetings of the profession this year bid fair to outrival those of any other year in the history of medicine. Both at home and abroad there is every prospect of large gatherings and interesting meetings. The meeting of the British Association for the advancement of science, will be held in Montreal, beginning on the 27th of August, and it has been arranged by the President (Dr. Sullivan), and the local committee, that the meeting of the Canada Medical Association, which is also to be held in Montreal this year, shall take place on the 25th, 26th, and 27th, so as immediately to precede the former meeting, and thus give members an opportunity of seeing and hearing the leading scientific men of Great Britain. A large number of the members of the British Association above referred to, are medical men, and it is expected that many of them will attend the meeting of the Canada Medical Association. This will greatly enhance the interest in both meetings, and we trust the members of the Canada Medical Association will show their appreciation by being present in large numbers, so as to make the meeting a success in every respect. The Ontario Medical Association, under the presidency of Dr. Daniel Clarke, Toronto, will hold its annual meeting in Hamilton on the 4th and 5th of June, and promises to be more than usually successful. A number of delegates are expected from various kindred associations, among others Drs. Hopkins, Vanderpool and Howe, from the New York State Society. Our brethren from the neighboring Republic will be cordially welcomed by the members of the Association, whom we hope to see present in large numbers.

The American Medical Association, under the presidency of Dr. Austin Flint, sr., will hold its 35th annual meeting in Washington, commencing on the 6th of May. This is the first year since the establishment of the Journal of the Association and some degree of interest will be manifested in the

financial success of the undertaking. The character and general matter of the journal itself, it must be conceded, has not met the just expectations of its friends, and some change will require to be made in the management if the journal is to occupy the position which its projectors intended.

The Baltimore and Ohio railway will run a special train from Chicago to Washington, on Sunday May 4th, at 3 p.m., at single fare, for the round trip.

The fifty-second annual meeting of the British Medical Association will be held in Belfast, July 29, 30, 31, and August 1st, under the presidency of Prof. Cuming, M.A., M.D., of Queen's College, Belfast. The address in medicine will be delivered by Sir Andrew Clark; in obstetrics by Geo. H. Kidd, M.D., of Dublin, and in physiology by Prof. Redfern, M.D., Belfast. The time of the meeting has been fixed so as not to interfere with the meeting of the International Medical Congress, which meets in Copenhagen on the 10th of August. Visitors after attending the meeting of the British Medical Association, will have ample time to travel to Copenhagen. A steamer will leave Hull (England), on August 2nd and 9th, and Leith (Scotland), on August 5th, for Copenhagen. There are other routes, but these will be found most convenient.

PUBLIC HEALTH.

The profession has displayed unusual activity in and about the Parliament buildings in Ottawa lately, with reference to the question of Public Health.

As a result of the deputations, representing the profession throughout the Dominion, that have interviewed the Government during the past few years, a scheme is in force in all the large towns for collecting mortuary statistics as a beginning in that important work. Overlooking this fact, and ignoring (though not intentionally) the body that has hitherto conducted the work, a meeting of the profession in Ottawa was recently held, at which a resolution was passed favoring the plan of collecting statistics referred to in our last issue, and a delegation was appointed to wait on the government and bring it under their notice. The plan proposed is an enlargement of the one now in force—its work being extended to the rural districts, the returns to be made by a practitioner in each district.

During the session of the Sanitary Convention a meeting of the visiting and resident physicians was held and the subject fully discussed. Upon the information that the Public Health Committee of the Canada Medical Association was in consultation with the government and at present was formulating a scheme to be presented at the next meeting to be held in August, the following resolution was passed and communicated to the government:

“That further consideration of any legislation in connection with public health be deferred until after the next meeting of the Canada Medical Association, in order to give the committee of that body time to report.”

A third deputation subsequently interviewed the members of the government representing the Quebec Sanitary Association, which has recently been formed among the French physicians of that Province. The object of this deputation was to solicit state aid for a French journal similar to that received by the journal published in Ontario.

It is very much to be regretted that so many deputations, representing separate interests, should wait upon the government. As long as this continues nothing will be accomplished. It would be infinitely better were all to unite with those who have hitherto been recognised as the leaders in this movement. Their representations would then command that attention to which they are so fully entitled.

TRINITY MEDICAL COLLEGE.—The following gentlemen have successfully passed the professional examination in the different years:

FELLOWSHIP DIPLOMA.—W. M. Brown, *Gold Medallist*, E. H. Williams, *1st Silver Medallist*, G. Fierheller, *2nd Silver Medallist*, S. A. McKeague, G. A. Bingham, G. L. Airth, R. Ovens, A. D. Lake, *Certificates of Honor*; J. E. W. Anderson, James E. Brown, O. M. Belfrey, J. C. Bell, D. A. Carmichael, W. J. Chambers, J. M. Cochrane, S. M. Dorland, P. N. Davey, A. V. Delaporte, E. T. Eede, D. Gow, A. Gillespie, E. N. Hall, W. S. Harrison, G. L. Johnston, T. H. Johnston, J. Johnston, T. M. Lawton, T. H. Mott, J. Standish McCullough, J. Stuart McCullough, T. McCullough, C. J. McIntyre, A. McKillop, T. Ovens, J. Park, W. E. Sprague, A. K. Sturgeon, A. Scott.

PRIMARY.—E. H. Williams, S. Scott, A. Graham, R. Lucy, W. H. McKague, O. M. Belfry, E. N. Fere, *Certificates of Honor*; J. M. Simmons, F. H.

Brennan, C. Lapp, D. C. Throop, W. H. Charlesworth, J. McC. Cleminson, W. V. Lynch, N. Allen, G. J. Dickison, J. G. Harper, H. J. Roberts, C. N. Sanford, O. Totten, P. E. Doolittle, J. F. Housberger, A. F. Bauman, C. S. Haultain, H. W. Hoover, W. W. Hay, L. Brock, A. M. Ewing, W. A. Williamson, A. B. Eadie, J. Evans, J. J. Cassidy, H. W. Darrell, W. W. Coldham, T. S. Farrar, R. West, W. W. Van Velsor, E. A. Fillmore, F. C. Hood, A. K. Sturgeon, A. C. Woodley, J. S. McCullough, J. H. Kilgour, W. H. Hamilton, W. O. Scott.

The following have passed on three or more subjects, H. S. Bingham, C. E. Stacey, T. M. Robinson, W. A. Wilson, and H. J. Caldwell.

SCHOLARSHIPS.—*First Years' Scholarship*.—1st, Jas. McLurg, 2nd, John McLurg; *Certificate of Honor*, J. Hamilton; *Second Years' do.*, S. Scott; *Third Years' do.*, J. R. Logan.

MCGILL UNIVERSITY, MONTREAL.—The following is a list of the successful candidates in this University:—

M.D., C.M.—W. A. Ferguson, B.A. *Holmes Gold Medallist*; J. P. McInerney, *Prizeman*; G. A. Graham, R. F. Ruttan, B.A., W. G. Johnston, E. J. Elderkin, T. B. Davies, *Honorable Mention*; J. L. Addison, Jos. A. Barrett, Hy. J. Clarke, John R. Church, Sheldon E. Cook, John A. Duncan, C. E. Gooding, Jas. A. Hutchison, C. H. Johnson, Patrick N. Kelly, Thos. H. Landor, J. H. McLellan, Wm. McClure, G. N. McLean, John C. Meahan, David B. Merritt, W. M. F. Nelson, Timothy O'Brien, Wm. Porteous, W. Scott Renner, L. D. Ross, Geo. B. Rowell, E. H. Smith, W. A. De W. Smith, H. E. Smyth, Felix D. Walker, S. F. Wilson, M. A.

PRIMARY.—S. Gustin, *Prizeman*; J. Elder, *Sutherland Gold Medallist*; N. G. Powne, H. S. Birkett, J. A. Kinloch, J. Elder, W. W. White, W. J. McCuaig, W. C. Crockett, G. H. Raymond, John L. Duffet, C. W. Wilson, F. J. Seery, G. B. Rowat, A. R. Turnbull, E. P. McCollum, and G. F. Palmer, *Honorable Mention*; J. H. Armitage, D. A. Cameron, D. Corsan, J. L. Clark, M. A. Craig, W. W. Doherty, Thos. M. Gairdner, J. B. Gibson, Geo. J. Gladman, J. H. Y. Grant, P. H. Hughes, H. J. McDonald, Thos. G. McGannon, J. W. McMeekin, J. M. McKay, A. T. Platt, W. P. Pringle, A. Raymond, F. D. Robertson, A. T. Schmidt, W. A. Smith, F. J. White, D. J. Wishart, A. N. Worthington.

Botany prize, 1st year, N. E. Powne and J. E. Gray; *Practical Anatomy*—1st year, D. L. Ross, 2nd year, H. S. Birkett; *Pathology*—E. C. Wood, *Prize*, F. G. Finley, *Honorable Mention*.

TRINITY UNIVERSITY.—The following is a list of the candidates who received degrees and honors

at the recent convocation at this University. The gentlemen were all students of Trinity Medical School.

M.D., C.M.—E. H. Williams, *University Gold Medallist*, W. M. Brown, J. L. Davidson, G. A. Bingham, *Certificates of Honor*; G. Fierheller, E. A. Hall, G. L. Airth, J. Johnston, J. Standish McCullough, S. A. McKeague, F. H. Johnston, D. Gow, A. Gillespie, S. M. Dorland, W. S. Harrison, E. J. Eede, J. M. Cochrane, A. D. Lake, A. McKillop, W. E. Sprague, Jas. S. McCullough, R. Ovens, T. Ovens, G. L. Johnston, W. J. Chambers, P. N. Davey, T. H. Mott, T. McCullough, O. M. Belfry, J. C. Bell, E. Furrer, A. V. Delaporte, J. E. Brown, J. E. W. Anderson, J. Park, E. A. Fillmore, J. H. Kilgour, A. V. Sturgeon, J. C. McIntyre, T. M. Lawton, D. N. Carmichael, W. H. Hamilton, W. O. Scott, A. Farncombe.

The following gentlemen who had previously received the degree of M.B. were also admitted to the degree of M.D., C.M.—W. H. Macdonald, F. Canfield, A. J. Gaviller, W. W. Geikie, W. T. Harris, D. McLeod, H. Robertson; A. M. Baines, T. C. Cowan, A. Davidson, S. W. Lamoreaux, H. Meikle, T. McK. Milroy, J. C. Mitchell, J. B. Gullen, E. M. Hoople, E. B. O'Reilly, J. T. Sutherland, E. R. Wood.

VICTORIA COLLEGE.—The following gentlemen have passed the professional examination in this University:

M.D., C.M.—A. C. Smith, G. H. Carveth, H. Bascom, C. M. Forster, T. W. Simpson, G. A. Cherry, J. E. Elliott, H. S. Martin, D. Campbell, E. F. Hixon, L. G. Langstaff, A. Sangster, S. E. C. McDowell, A. T. Rice, C. W. Hunt, G. S. Wattam, J. H. Joliffe, J. O. Orr, W. A. Robertson, J. W. Campbell, A. Broadfoot, E. Beemer, J. R. Phillips, C. W. Chaffee, J. H. C. Willoughby.

Primary.—W. J. Parry, J. E. Pichard, W. C. Heggie, H. A. Wright, W. C. McKinnon, W. J. Teasdale, J. A. Rutherford, J. R. Dales, D. M. Williams, W. H. Wright, G. Siminton, C. E. Lawrence, L. L. Hooper, C. J. Smith, J. M. Forster, P. P. Park, G. Sanson, C. A. Hodgetts, E. E. King, G. A. McDiarmid, L. G. Smith, A. McGilivray, T. J. McDonald, S. West, R. J. Wood, A. B. Riddell, W. R. Baker, C. J. Hastings.

COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—The following candidates have successfully passed the Council examination:—

FINAL.—J. L. Addison, J. E. W. Anderson, G. A. Bingham, Elizabeth Beatty, F. D. Canfield, G. H. Carveth, J. W. Clerke, D. Campbell, J. M. Cochrane, E. M. Cook, R. Coughlan, W. N. Davis, H. R. Duff, J. S. Draper, J. E. Elliott, G. Fierheller, C. M. Foster, R. N. Fraser, J. Ferguson,

E. C. Fielde, W. R. Hall, E. F. Hixon, W. H. Hamilton, C. W. Hunt, John Herald, E. A. Hall, G. L. Johnston, John A. Jones, F. H. Johnston, F. D. Kent, L. G. Langstaff, A. D. Lake, H. S. Martin, T. H. Mott, A. F. McKenzie, Alice McGillivray, J. O. Orr, T. Ovens, J. Park, J. W. Paterson, A. F. Pringle, L. G. Routhier, W. N. Robertson, A. T. Rice, R. F. Ruttan, W. O. Scott, G. Shoults, A. Sangster, R. A. Smith, W. E. Sprague, S. Stewart, J. Spence, D. M. Staebler, R. L. Stewart, J. E. Stirling, Elizabeth Smith, H. E. Webster, W. J. Young.

PRIMARY.—J. E. W. Anderson, A. W. Bigelow, R. M. Bateman, C. H. Britton, H. S. Birkett, L. Brock, John Barber, F. D. Canfield, E. M. Cook, J. J. Cassidy, H. C. Cunningham, L. F. Cutten, J. M. Cleminson, W. H. Charlesworth, W. N. Davis, P. E. Doolittle, J. R. Dales, A. W. Dwyer, G. J. Dickson, A. H. Edmison, E. H. Earle, W. M. English, A. B. Eadie, D. D. Ellis, C. M. Foster, Jas. Ferguson, H. B. Ford, E. C. Fielde, J. H. Y. Grant, A. Graham, W. R. Hall, W. H. Hamilton, H. J. Hamilton, W. C. Heggie, P. H. Hughes, W. W. Hay, D. R. Johnston, John A. Jones, W. A. Kyle, W. V. Lynch, C. Lapp, A. T. Little, Robt. Lucy, W. Logie, M. Mather, L. J. Mothersill, S. J. Mellow, J. Marty, T. H. Mott, W. H. McKague, G. McKenzie, N. McCormick, C. T. Norcker, A. B. Osborne, J. Park, J. W. Peaker, J. E. Pickard, G. A. Peters, W. T. Parry, L. G. Routhier, A. T. Rice, D. G. Russell, J. A. Rutherford, Helen Reynolds, W. O. Scott, Geo. Shoults, A. M. Shaver, G. Simenton, G. Sanson, D. M. Staebler, C. F. Snelgrove, C. M. Sandford, C. E. Stacey, W. E. Sprague, J. A. Stirling, Stuart Scott, R. A. Smith, C. J. Smith, J. N. Simmons, L. W. Thompson, O. Totten, G. Veitch, W. A. Wilson, W. H. Wright, D. J. G. Wishart, W. J. Weekes, F. Winnett, W. J. Young.

ASSESSMENT DUES.—The Ontario Medical Council is now taking active measures to collect the arrears of assessment. No doubt the Council feels some reluctance in taking active steps, as the members of the College, in arrears, will be put to unnecessary expense, as happened with the cases that were placed in court for collection a short time ago, the costs in some cases amounting to as much as the claim. The clause in the act bearing on this point (sec. xxvii.) reads as follows:—"Each member of the College shall pay to the Registrar, or any person deputed by the Registrar to receive it, such annual fee as may be determined by by-law of the Council, not less than one nor more than two dollars, towards the general expenses of the College, which last mentioned fee shall be payable on the first day of January, in the year in which

the same is imposed, and such fee shall be deemed to be a debt due by the member to the college, and be recoverable with costs of suit, in the name of the College of Physicians and Surgeons of Ontario."

PERPETUAL INJUNCTION.—In the U. S. Circuit Court, Maryland, it was decreed, on the 10th of March, 1883, that a perpetual injunction be issued against Louis E. Wetter, and others, restraining them from imitating the labels of the Rumford Chemical Works. It was also decreed that the plaintiffs be entitled to receive the profits which had been diverted by reason of the infringement, and the defendants were ordered to pay all costs. Not long since, several parties were heavily fined for violating the injunction of the Supreme Court restraining all persons from offering for sale "Acid Phosphate" (so called) in any package which shall be a substantial or colorable imitation of Horsford's Acid Phosphate.

MALTOPEPSYN.—We notice with pleasure the large and increasing demand for maltopepsyn by the medical profession, and congratulate Mr. Hazen Morse upon having met with such gratifying success. Maltopepsyn is undoubtedly one of the most valuable aids to digestion we have, which fact has been attested by most of our leading practitioners. It has also met the approval of the profession in England, some five thousand bottles having been used there during the past year. We cordially recommend it to our medical brethren as a thoroughly reliable remedy, and valuable in the treatment of cholera infantum, and other infantile ailments, etc.

A CAUTION.—Dr. Walton, of Parry Sound, sends us a letter cautioning his brethren in the profession against an advertisement in the Toronto papers, stating that there is a good opening in that place. Two medical gentlemen have already, at considerable expense, visited the place, and after a stay of a few days, left in disgust. Parry Sound is a small village on the Georgian Bay, and there are not upwards of forty farm houses within a radius of ten miles. The motives which prompted the insertion, he avers to be mere personal spite and political animosity on the part of a certain individual.

CALCIUM SULPHIDE IN DIABETES.—This remedy has been introduced in the treatment of diabetes

mellitus. In an article in the *N. Y. Med. Journal* Dr. Caldwell speaks in very high terms of its efficacy and alludes to other physicians who have used it with excellent results. Dr. N. C. Husted, who was himself afflicted with the disease made a complete and lasting recovery under its use. Drs. Flint, Lellman and others have also had good results from its administration in this affection.

CHLORIDE OF SODIUM IN PLEURITIC EFFUSION.—A case was reported recently in the *British Med. Journal*, in which the rapid absorption of pleuritic effusion had been accomplished by the administration of half-drachm doses of chloride of sodium every hour. All fluids were at the same time forbidden the patient. There was great dyspnoea with cyanosis and the patient refused aspiration. Improvement under the above treatment was noticeable within two hours, and in six or eight hours the cyanosis had disappeared entirely.

ELECTRIC BATTERIES.—The Jerome Kidder Manufacturing Co., of 820 Broadway, New York, received the "Medal of Superiority" from the American Institute, in the fall of 1883, over three competitors, for their superior Electro-Medical Apparatus. This old established house needs no commendation for the excellence both of design and manufacture, which render their machines a standard of quality all over the country.

HOT MILK AS A RESTORATIVE.—A writer in the *Medical Times and Gazette* recommends the use of hot milk as a restorative. Milk when heated above 100° F. loses its sweetness and density, but has a most beneficial influence over mind and body when exhausted by labor or mental strain. Its effects are more invigorating and enduring than those of alcoholic stimulants.

HOT LEMONADE FOR DIARRHOEA.—Some people prefer hot lemonade to the usual form, but it is only recently that we have seen it recommended in diarrhoea. Dr. Vigouroux recommends a glass of hot lemonade every hour, or half hour, as an easy, agreeable, and efficient treatment for diarrhoea.

OPIUM IN ABORTION.—Prof. Parvin, of Philadelphia, says that the best mode of giving opium to prevent abortion is by the rectum. He gives from twenty to thirty drops of laudanum, and repeats it as often as necessary.

RESIGNATIONS.—Prof. Alfred Stillé has resigned the chair of Materia Medica and Therapeutics in the University of Pennsylvania, after twenty years' incumbency. Dr. D. Hayes Agnew has resigned from the staff of the Pennsylvania Hospital.

The citizens of Montreal having subscribed \$50,000 towards the endowment fund of McGill Medical Faculty, Hon. D. A. Smith has fulfilled his promise of granting \$50,000 to the same object.

CORONER.—Dr. D. M. Fisher, of Warton, has been appointed coroner for the County Bruce.

The Death of Prince Leopold.

In common with our fellow-subjects at home and abroad, it becomes our painful duty to record the death of Prince Leopold, Duke of Albany, the youngest son of our beloved Queen. The sympathy for Her Majesty and the bereaved Duchess which his sudden death has evoked, shows the deep loyalty and affection of the nation towards the Royal family. The late Prince was especially one to whom the nation looked with assurance of ready aid in all questions involving moral and intellectual progress. No authentic report of the cause of his sudden demise has as yet been published, and no autopsy appears to have been made. It has been currently reported that he was the subject of the hemorrhagic diathesis, and that the immediate cause of death was a convulsion. The *London Lancet*, in commenting on his death, pays a graceful and becoming tribute to his lamented father the Prince Consort, whom he is said to have much resembled in features and in mind. He was much endeared to all classes of the people by his kindness of manner, generous sympathy, cultivated tastes and scholarly intelligence. His sudden demise on the threshold of a life rich in promise of future usefulness, when he was beginning to be loved and held in homage, not only for his illustrious rank, but also for his own natural good qualities, has cast a sad gloom over the entire nation, which will not soon be dispelled.

Books and Pamphlets.

DICTIONARY OF MEDICINE INCLUDING GENERAL PATHOLOGY, THERAPEUTICS, HYGIENE, AND THE DISEASES OF WOMEN AND CHILDREN by various authors, edited by Richard Quain, M.D., F.R.S. London, Eng. Fourth edition. New York: D. Appleton & Co.

We have been favored with a copy of this excellent work by the publishers, and have had much pleasure in looking over its contents. The work is already well and favorably known to many leading members of the profession. To those who have not been acquainted with former editions, we would say that it is a most useful and convenient work for reference at all times. The articles are written by some of the most eminent men in the profession, the list embracing such names as Adams, Aitken, Balfour, Bastian, Bennett, Bristowe, Broadbent, Brown Sequard, Brunton, Carpenter, Clarke, Curling, Cormack, Matthews Duncan, Farquharson, Fenwick, Ferrier, Fox, Gowers, Holmes, Hutchison, Jenner, Latham, Liveing, McKenzie, Murchison, Paget, Playfair, Roberts, Simon, Thompson, Thorowgood, Williams, Wilson, and a host of others of equal prominence. The diseases are taken up in alphabetical order and are fully discussed in regard to clinical history, pathology and treatment. The work is illustrated wherever illustrations can be of service in elucidation of the text. It is upon the whole a most valuable work, alike of interest to young and old, student and practitioner, and no medical library can be said to be complete without it.

THE CANADA EDUCATIONAL MONTHLY; Toronto: \$1.50 a year.

The April number of this standard independent magazine is to hand, and is replete with matter interesting alike to the professional and general reader. No school journal in America aims so high, or has such an able corps of regular contributors as *The Monthly*. The present number contains President Wilson's Inaugural Address on "Free Public Libraries;" Mr. Rye's paper on "University Life in the Early Part of the 17th Century;" Mr. Tattersall's on "Educational Theories and Theorists;" and Mr. Ward's on "The Duties of the Teacher." The University, Science and School Departments are full of interest to teachers and students. The Editorial Notes on

current educational questions are judicious and impartial, and indicate an intimate acquaintance with school affairs. The Educational Intelligence and Editor's Table are admirable features. We notice that the magazine is made the medium of official communication.

A TREATISE ON PHARMACY. By Edward Parrish. Fifth edition, enlarged and revised by Thomas S. Wiegand. Philadelphia: Henry C. Lea's Son & Co. Toronto: Williamson & Co.

In this excellent work for the student of Pharmacy will be found working formulæ for the use of the practical manipulator; comments upon the use and properties of the officinal preparations, processes for preparing and dispensing medicines; composition of chemical compounds—prominent properties and doses; modes of measuring, regulating, and applying heat for pharmaceutical purposes; on the art of selecting and combining medicines; pharmacy in its relation to organic chemistry; galenic and extemporaneous pharmacy. The student of Pharmacy will find in this volume a mine of information, brought up to the present standard of Chemical and Pharmaceutical Science.

THERAPEUTIC HANDBOOK OF THE U. S. PHARMACOPEIA. By Robert T. Edes, A.B., M.D., Harvard. New York: Wm. Wood & Co. Toronto: Williamson & Co.

This book admirably fulfils a requirement for the student as a commentary on the U. S. Pharmacopœia, which is altogether too bulky a volume for anything but a work of reference. A succinct treatise therefore on drug action, physiological and therapeutic, dosage, incompatible substances, etc., is a great boon to the overworked pupil of the present day and cannot fail to be appreciated by him when the time for final examination approaches. The book is well printed and will be found a valuable addition to the works already published on the same subject.

A MANUAL OF OBSTETRICS. By A. F. A. King, M.D., Prof. of Obstetrics, Columbia University, Washington, with 59 illustrations. Second edition. Philadelphia: H. C. Lea's Son & Co.

It is only a short time since the issue of this work, and it must be very gratifying to the author to find such a rapid exhaustion of the first edition. The present edition has been revised and corrected, and such additions made as were necessary to bring

it fully up to the present knowledge of the subject. The work will be found useful to those for whom it is designed.

A PRACTICAL TREATISE ON SURGICAL DIAGNOSIS, for practitioners and students of medicine, by Ambrose L. Ranney, A.M. M.D., of New York. Third edition; revised, enlarged, and profusely illustrated. New York: William Wood & Co. Toronto: Hart & Co.

This work is designed as a manual of surgical diagnosis for students and practitioners of medicine, and as such will be found very serviceable for occasional reference. That it has been favorably received by the profession in the United States, may be inferred from the fact, that although a recent work, it has already reached the third edition. Much of the information given is in a tabulated form, and to some minds this is the readiest method of imparting instruction.

EPITOME OF SKIN DISEASES; with formulæ for students and practitioners; by Tilbury Fox, M.D. Third American edition. Philadelphia: H. C. Lea's, Son & Co. Toronto: Hart & Co.

The present edition of this well-known work has been edited by T. Colcott Fox, M.D., brother of the author. The classification of skin diseases adopted is the one promulgated by the American Dermatological Association. The style is clear and concise, the arrangement simple and convenient, and the work cannot fail to prove of great value to the student of dermatology.

A GUIDE TO AMERICAN MEDICAL STUDENTS IN EUROPE. By Henry Hun, M.D., Prof. of Nervous Diseases, Albany Medical College. New York: Wm. Wood & Co.

We have been much pleased with the perusal of this interesting little book. The author has been over the ground, and knows whereof he writes. The information supplied will be found of great practical value to all students and practitioners who intend visiting Europe to add to their store of medical knowledge.

THE STUDENTS HAND-BOOK OF FORENSIC MEDICINE AND MEDICAL POLICE, by H. Aubrey Hubbard, M.B.C.M., F.R.C.S.E., Lecturer on Medical Jurisprudence in the extra-academical school, Edinburgh. Fourth edition, revised. Edinburgh: E. & S. Livingstone.

The fourth edition of this admirable work has been thoroughly revised. New sections have been

added on criminal proceedings, somnambulism in its legal relations, and on the action of poisons, and many portions have been enlarged and rewritten, so that the work is now as complete a hand-book on this subject as is to be found in the English language. We have therefore great pleasure in recommending the work to our Canadian confères, and especially as a convenient and reliable text-book for the use of medical students during their college course and in preparing for their examinations. The work is concise, clearly and well written, and embraces all phases of the subject usually treated of in similar works, and all within the compass of 600 pages duodecimo.

ILLUSTRATED MEDICINE AND SURGERY.—Vol. II., No. IV., Oct., 1883. Edited by Drs. George Henry Fox and Fred. R. Sturges. New York: E. B. Treat & Co., 757 Broadway.

This work, which has been previously noticed in these columns, still keeps up its reputation for excellence in illustration and completeness of detail. The present number contains 21 illustrations. We commend the work to the attention of the profession in Canada.

VETERINARY MEDICINE AND SURGERY IN DISEASES AND INJURIES OF THE HORSE. By F. O. Kirby. Illustrated by four colored plates and one hundred and sixty-eight wood engravings. Cloth; 8vo.; pp. 326. Wm. Wood & Co., 1883. Toronto: Hart & Co.

In this work is presented in a concise and practical form, the diseases and injuries of the horse, and their appropriate treatment.

A POCKET AIDE-MEMOIRE, compiled specially for the instruction of the ambulance corps of the Dufferin Rifles of Canada. By William T. Harris, M.D., C.M., Surgeon Dufferin Rifles.

Births, Marriages and Deaths.

On the 10th of April, John F. Coad, M.R.C.S. Eng., of East Zorra, Ont., aged 72 years.

On the 4th of February, C. Deguise, M.D., of Quebec, aged — years.

On the 29th March, Dr. Wm. James, of Burgessville, in his 36th year.

On the 21st of March, P. N. Leclair, M.D. (McGill), of North Lancaster, Ont., aged 48 years.