DOMINION MEDICAL MONTHLY

AND ONTARIO MEDICAL JOURNAL

VOL. XIV. TORONTO, APRIL, 1900. No. 4.

Original Articles

No paper published, or to be published elsewhere as original, will be accepted in this department.

A CASE OF SMALLPOX, RECENTLY DISCHARGED FROM THE ISOLATION HOSPITAL IN THIS CITY.

BY J. G. LAMONT, M.D., BRANTFORD.

T—— C——, aged 28, of Cleveland, complained on January 16th of malaise, headache, pain in back and extremities. Was unable to work until January 19th, when he felt better, and resumed work on January 20th. Was immediately seized with severe chills, high fever, and much pain in head and back. He called a Cleveland physician, who diagnosed the case la grippe. The patient decided to obtain leave of absence for two weeks and return to his home in Brantford. Left Cleveland on 25th, and reached this city same evening. On 26th, he had considerable soreness of mouth and throat, and called his local physician who, although at once suspicious of the nature of the case, wisely reserved an opinion until the following day. January 27th, the discrete papular rash had more fully developed upon the skin, and presented the shotty feel and otherwise typical appearance of variola. The case was promptly quarantined, and reported to the city health department, which at once made necessary arrange-

ments for conveying patient to the smallpox hospital, where he was placed under the care of Dr. Proudfoot.

January 28th. Temperature 102; pulse 93. Eruption vesicular upon the face and trunk, also upon mucous membrane of pharynx and buccal surfaces.

29th to 31st. Eruption umbilicated and pustular in places. Number of papules increasing and developing upon extremities, and upon palmar and plantar surfaces, where they were productive of considerable discomfort.

February 1st to 10th. Course of disease uneventful. Temperature, from time of complete development of pustulation, ranged between 98 and 101 degrees. Pustules gradually formed crusts and healed. Comparatively few papules became pustular. No eye complications developed.

Treatment: Isolation; rest in bed; regulation of excreta; aristol and vitogen for local antisepsis; borolyptol for mouth-wash; iron and quinine during convalescence.

The patient had been vaccinated in earlier life, which may in this case have ameliorated the severity of the disease and shortened its course. No exact data could be secured with reference to constitutional symptoms in early stage. Amount of secondary fever and delirium slight at any stage.

No doubt the mildness of the type of smallpox which has appeared in various parts of the province during the past year has in some measure at least been due to vaccination. Increased immigration and improved facilities for railway travel give greater prominence to the need for enforcement of the Act by local boards of health. This need is more especially manifest in outlying districts where vaccination has been systematically neglected for decades, and in the public schools and large factories of our more populous centres where contact with recent arrivals from infected districts is at all times likely to occur.

Reports of Societies

TORONTO CLINICAL SOCIETY.

Stated meeting, April 4th, 1900.

The president, Dr. Bingham, occupied the chair. Fellows present: Aikins, Anderson, Fenton, Hamilton, Badgerow, King, Rudolf, McIlwraith, Small, Trow, Bruce, Cameron, Parsons, Pepler, Dwyer, Orr, Elliott. Visitors: Spence and Dean of the T. G. H. Nomination for fellowship: Dr. J. H. McConnell, by Drs. Bingham and Elliott. Nomination of Officers: President, Dr. W. H. B. Aikins; Vice-President, Dr. George A. Peters; Corresponding Secretary, Dr. A. A. Small; Recording Secretary, Dr. George Elliott; Treasurer, Dr. W. H. Pepler; Executive Committee, Drs. Hamilton, Parsons, King, Bruce, Rudolf, McIlwraith, Dwyer, Anderson, Badgerow, Fotheringham, Fenton. Silverthorn, and Trow—five of these to be elected at the next meeting in May.

CANCER OF RECTUM AND PROSTATE.

Dr. E. E. King presented a patient, a man of 59 years, upon whom he had operated for carcinoma of the rectum. Patient had always been healthy. In 1897, two years before seen by the surgeon, he noticed a condition of irritation around the anus, with the passage of slimy material and some blood. Had a severe hemorrhage in August, 1899; on the following day he had another severe hemorrhage. Patient came under Dr. King's care September 26th, 1899; and on the 11th of October he excised the tumor presented. The mass extended from the sphincter, which it involved, upwards three and one-half inches, involving the whole of the circumference of the bowel, and there were enlarged inguinal glands, an interesting fact because it is exceedingly rare that these glands are involved. Only five months have elapsed since the operation, and he has gained somewhat in the neighborhood of twenty pounds. The operation performed was a modified Kraske. An incision was made over the coccyx, which was removed; and the surgeon was thus able to get above the mass, and draw down the gut without opening the peritoneum. The patient was examined by the Fellows. Dr. King reported a second case, aged 56 years at the time of operation. Bowel movements had been slimy and contaminated with blood for one and a half years prior to the time of entering the Toronto

General Hospital, in 1894. Had been operated upon then by a confrere, and presumably a portion of the growth excised. This did not unite, and there was an ulcerated condition in December of 1894, when he came under Dr. King's care. Suspecting syphilis, he was placed on iodide and watched carefully for a month, the ulcerated surface being cauterized. This treatment proved futile. Colotomy was then performed, the growth excised, and there was recurrence at the edge. In 1895 had third excision of the recurrence. Six months another recurrence took place at the junction of the skin and mucous membrane. This was the last recurrence. About June of 1898 it was decided to close up the colotomy. He has gained since that operation about forty pounds, and has comparatively good health. He has fair control over his movements, and has fifteen to twenty minutes' notification that the bowels are about to evacuate. He can also retain the ordinary solid movements for ten minutes or so. The third case reported by Dr. King showed that the family history was entirely free, except that the mother had had a tumor in her neck, which was said to have been removed by a plaster, the patient subsequently living until she was seventy-five years of age. In 1895, this patient had a very severe pain over the iliac region and lower part of the spine and left side generally. She went into the General Hospital and operation was performed, which was said to be the removal of the growth. It recurred within a year, and when seen by Dr. King, she had very severe cancer of the rectum. In this case the peritoneum was opened and the growth taken away very freely. Recurrence took place, and this patient is now dying. Case No. 4 was peculiarly unique. Patient was 28 years of age. Mother and father living, healthy; brothers and sisters healthy. Maternal grandfather had a cancer of the lip removed some years after his death, by plaster. At seven years of age she was injured by being hit in the hip with a large stone. Severe pain developed in forty-eight hours; and between that time and the next ten or twelve years, she was in bed and out of bed at intervals of six months, and developed a severe form of hip disease. Photos of the case were here presented. The abscess formations and the fistulæ closed, until she was taken down with an attack of typhoid fever, when these broke out again, and she came to St. Michael's Hospital in 1894. At that time she had a large mass involving the left side of the anus, perineum and the labia majora, extending into the buttock, almost as far as the greater trochanter. Its extent was about seven or eight inches long by six inches wide. It was impossible to pass the finger above the diseased area. The mass was cut through

into perfectly healthy tissue and dissected up through the fat and down to the muscles, exposing the greater and lesser notches, opening the perineum and removing about two-thirds of the area. The bowel was brought down and stretched, and covered about three-quarters of the whole surface. Dr. King did four operations on this patient, and so far as the removal of the cancer is concerned, feels that one is not saying too much when he claims it to be a successful removal of the cancer. The patient almost succumbed during the operation, as she is suffering from chronic Bright's disease. The patient has gained 18 to 20 pounds. Dr. King then dealt with the statistics on this subject.

DR. BINGHAM stated, in discussing the paper, that the original Kraske operation was intended for conditions where the mass was high up in the bowel; it was then able to continue the functions of the sphincter. Of course, if there was any involvement of the sphincter, it should be removed. He also spoke of twisting of the bowel in these cases to effect a final cure.

BULLET WOUND OF ORBIT.

DR. H. A. BRUCE stated he was unable to present the patient, as he did not dare to tax his strength in coming from the hospital. A boy of fifteen years of age had been practising with a 22-calibre revolver at a target, while sitting on a log in the country. Two shots had been discharged, when he examined the revolver, holding it in both hands, looking down at the muzzle pointed towards him. That is all he remembers. On regaining consciousness he walked two miles to town to consult a doctor. An unsuccessful attempt having been made to locate the bullet, the lad came down to the city. The bullet had passed through the eyelashes of the lower lid near the external canthus. The X-Ray apparatus at the General was pressed into service, but it was quite impossible to outline clearly the bones of the skull, although the bones of the extremities could be seen clearly. Chloroform was administered, and with a probe through the opening in the lower lid, entering the orbit and passing along the outer wall of the orbit (the bone being quite bare of periosteum) the bullet was located about one and a half inches in, and could be easily moved by the probe. The external opening was slightly increased. With a pair of artery forceps, the bullet was gotten hold of easily and extracted. It was lying just behind the eyeball, about the middle of the orbit, probably against the optic nerve. It had grazed the orbital surface of the malar bone and the orbital surface of the greater wing of the sphenoid. There are one or two points of interest as regards the symptoms. The boy could move his eye, except down-

wards, when he had pain. The inferior rectus was pressed upon during contraction and caused the pain. He could see to the right of the middle line, but could not see to the left of the middle line. The bullet having been removed, it does not now cause him pain to look down. The bullet was considerably deformed.

DR. FENTON spoke of a similar case of bullet wound, shot from a small calibre rifle at short range. This bullet entered the nose, there being no external wound, passed through the lachrymal bone, entered the orbit, through the great wing of the sphenoid, then through the temporo-sphenoidal lobe, finally lodging in the occipital fossa.

A CASE OF ADDISON'S DISEASE.

DR. R. J. DWYER read at considerable length notes of a case of this disease, which presented all the classical features of the disease. It occurred in a man aged 38 years, born in England, a machinist by trade, but on the sea for a good deal of his life. He was admitted to St. Michael's Hospital December 22nd, 1899. As regards his family history, the father is living, but the mother is dead. She was sick six years with spinal trouble before her death, which suggests tubercular disease. In reference to personal history, he weighed 146 pounds on admission, but used to weigh 160 pounds. Five years ago he was in Australia; malaria on return to England; in bed nine weeks. Was always subject to headaches. Drank heavily for several years, also smoked. Present illness began with nausea and vomiting in the morning. He would feel better during the day. Headache principally in the morning, which would disappear when out in the open air, Breathlessness and fluttering of the heart appeared. Shortly after Christmas, 1898, his wife first noticed any change in color. Skin became dark, principally the face and hands. This contrasted with the body, which was quite white. He continued at his work until June, when he had to give up on account of weakness, which increased. After he discontinued work, was able to go about for two months before coming into the hospital in December. Sometimes he would have attacks of diarrhea, alternating with constipation. He was very languid and drowsy during the day and restless at night. Temperature sub-normal. Pulse varied from 72 to 100. The yellowish-brown color was very marked on the neck. The conjunctivæ presented marked contrast, being comparatively pale. The discoloration was mostly marked on the face, back of the neck, perineal sulcus, scrotum and penis, which was quite black. The mouth presented an interesting condition. The presence of very black pigment-

ation on the inner surface of the gums, and also and still more striking on the under surface of the tongue, was an interesting feature. The whole under surface of the tongue was absolutely black. Respirations ran at twenty. The patient died on the 29th of December, apparently from syncope. At the post-mortem examination, tubercular areas were found in the lungs, liver, and a solitary tubercular ulcer in the small intestine, situated about three or four feet from the ileo-cæcal valve. There was some enlargement of the spleen. The right supra-renal capsule was very hard and dense, and the appearance of the normal gland was destroyed. It was apparently converted into a hard fibrous mass. The left one was increased in size. Sections of each were made and caseous deposits found abundantly.

DR. PARSONS, who made the sections, stated there was most extensive tuberculosis present.

GEORGE ELLIOTT,
Recording Secretary.

LAMBTON MEDICAL ASSOCIATION.

The annual meeting of the Lambton County Medical Association was held in the Brown Block, Watford, on Wednesday afternoon, February 14th. Members present: Drs. McAlpine and Calder, Petrolea; B. C. H. Harvey, Alvinston; Scott, Courtright; Watson, Arkona; Wickett, Auld, Gibson and Newell, Watford; Elliot, Napier; A. Thompson, Strathroy; B. E. McKenzie, Toronto. The following officers were elected: President, Dr. McAlpine, Petrolea; Vice, Dr. Logie, Sarnia; Com. on Ethics, Drs. Gibson, Scott and Sturgeon; Auditors, Drs. Newell and Wickett. Dr. Calder read a paper on "Gastric Ulcers," and Dr. McKenzie one on "Club Foot." The next meeting will be held in Wyoming on Wednesday, May 8th. The local members of the profession entertained the visitors at supper at the Taylor House.

Special Selections.

GASTROPTOSIS.

BY ACHILLES ROSE, M.D.,
Instructor in Diseases of the Stomach, New York Post-Graduate Medical School and Hospital.

We are born with our stomachs standing vertically, but during the first period of extrauterine life this organ assumes the normal, that is, an almost horizontal position. Cases in which the stomach has remained in its fetal, that is, in the vertical position, have not been observed. In infants of a certain age the normal (nearly horizontal position) is invariably found. With advancing age of the children, however, displacements occur. It is said that such displacements happen more frequently in girls than in boys. Meinert found among 50 girls of 12 years of age almost every second one with a dislocated stomach, while among the patients of his gynecological clinic there were more than 90 per cent. with anomalous position of this organ. He judges that among male adults such deviation is found only in five per cent. Certain it is that gastroptosis is of more frequent occurrence in women than in men.

As to the frequency of ptosis of the different abdominal organs, gastroptosis is, according to Langenhaus, the most numerous; in his report on 100 cases of enteroptosis that malplacement was wanting in only five; nephroptosis was present in 47; in the five cases mentioned nephroptosis existed without any other abdominal organ being displaced, in the others it was associated with gastroptosis. In three cases the spleen, and in 18 the liver, were included in the ptosis, liver and spleen only in Landau cases.

Gastroptosis is a lowered position of the pylorus and of the lesser curvature. The definition of the lower border of the stomach alone is not diagnostic, since this may be the characteristic symptom of a large stomach as well. Here we have to distinguish between ectasia and ptosis, without knowing the situation of the lesser curvature, neither a general increase of volume nor an abnormally lower position of the stomach, nor a combination of both can be diagnosticated. Gastroptosis can only be diagnosticated by means of inflation of the stomach or the gastrodiaphane.

Kussmaul was the first who called attention to the descent and the vertical position as well as to the loop form of the stomach.

A complete gastroptosis, a descent of the entire stomach, is not possible, since the cardiac orifice cannot change its position in the region of the twelfth thoracic rib.

Discussion on gastroptosis has been very lively during recent years, and the opinions of the different authors in regard to etiology, as we shall see, differ. They also differ with regard to a number of morbid conditions which have been connected, correctly or incorrectly, with gastroptosis. This lively controversy has been the means of enlarging our knowledge in this field.

There can be no doubt but that it is a very important matter to speak of the etiology of the gastroptosis, for the knowledge of the etiology in a given case will serve as a guide for our therapeutical action.

Gastroptoses are of interest in every-day practice. The pathological changes in these cases are subject to special therapy, which is as rational as it is in most instances successful. The study of the various causes of the pathological changes leading to gastroptosis is of practical value.

As we have already seen, *gastroptosis may form part of general enteroptosis,* or as some prefer to call it splanchnoptosis, *but it may exist by itself, may happen without coexisting nephroptosis, at any rate it is the gastroptosis which in most instances demands principally our attention.*

The displacement of the stomach and other abdominal organs is often an acquired condition, but recent investigations have furnished evidence that a congenital disposition commonly plays a most essential part.

According to different etiological conditions we have to distinguish different forms of gastroptosis. The oversight of such distinction between various kinds of gastroptosis of diverse origin has given rise to so many differing explanations. The different forms of gastroptosis have, according to their etiology, distinct clinical significance.

Gastroptosis in adults of both sexes may be the manifestation of constitutional defects and anomalies, and first of all paralytic thorax, chicken breast or funnel-shaped breast. We find displacement of the stomach in men or nulliparæ of tender and lean habit with narrow, long, precociously ossified thorax, wide intercostal spaces and frequently Stiller's stigma of fluctuating tenth rib: in short, it is found in persons with typical phthisical habit. Indeed, gastroptosis is very frequently present in phthisical patients, and it is rare in strong and robust people except when caused by trauma or by peritonitic adhesions. There are exceptional cases of movable spleen and kidney, even gastroptosis of

purely local nature happening in robust individuals, in such cases the subjective painful symptoms may be missing. On the other hand, gastroptosis is frequent in poorly nourished individuals, and among the feeble saleswomen who are forced to be standing for eight hours or more during the day. These women should be advised to attend to housework, as being more suitable for their constitution, as well as their physical and mental welfare.

The reason why patients with long, narrow thorax are especially subject to gastroptosis is this: In such patients the diaphragm occupies a position lower down than normally, on account of the increased vertical diameter of the lungs. In cases of emphysema of the lungs and exudation in the pleural cavity there is still a lower level of the diaphragm. In these conditions the organs situated below the diaphragm cannot find sufficient space in the hypochondrium and are obliged to descend.

In the constitutional form it is not often that spleen and liver are sunk down, the kidney in men with gastroptosis of the constitutional form is less often felt than in cases of the constitutional form in women.

The downward displacement of the stomach is associated with change of its form. It assumes in the higher degrees of such displacement either the shape of a loop, with its convexity down, or a vertical position, similar to that of the fetal period; or again, a vertical direction has developed by the sinking down of the pylorus to such an extent that the pylorus stands nearly vertically below the cardiac orifice.

Far down displacement, marked changes of form, and real disfigurements of the stomach are found in some cases of kyphosis and scolio-kyphosis. Fleiner describes a case in which the splashing sound could be produced immediately over the symphysis, while the apex beat of the heart was felt in the axilla. In this case, however, notwithstanding these anomalies, in the situation of the viscera there existed no marked disturbance of the gastric functions.

Next to the constitutional cases of which we have spoken, there are others caused by local and, as a rule, mechanical disorders, and these disorders may exist in the stomach itself or outside of it.

Permanent motor insufficiency produces gastroptosis, as also do tumors of the pylorus or of the lesser curvature which are weighing on the stomach. In the latter instances the expelling power of the organ may remain intact.

Gastroptosis may be caused by hernia, especially hernia of the mesentery; above all may hernia in the linea alba give rise to

gastroptosis; in these cases also the expelling power of the stomach may remain intact.

Tumors of the spleen and liver may also cause gastroptosis.

Another group of cases owes its existence to enlargement of the abdominal space. The largest contingent of these is furnished by the post-puerperal types of gastroptosis, and these have been called Landau cases, because Landau first described them thoroughly. This form of gastroptosis may exist without giving rise to symptoms. If a woman has given birth to many children, there occurs a physiological relaxation of the abdominal walls which leads to a physiological descent of the viscera of moderate degree without symptoms.

Men, after having been relieved from obesity by heroic diet, or treatment, may acquire gastroptosis. Gastroptosis, in these instances, puerperal as well as after obesity cure, is the result of adaption to space.

The activity of the abdominal muscles aids in a manner not sufficiently explained to fix the abdominal organs in their physiological position. Relaxation of this apparatus, which supports the abdominal organs in an unexplained manner, forms, therefore, the first etiological momentum in puerperal and in post obesitam enteroptosis. It is true that relaxation of the abdominal muscles is to a certain degree compensated by increased expansion of the intestine, but a complete compensation is hardly ever established. Women who do not receive proper attention immediately after confinement may acquire or suffer increase of pre-existing gastroptosis.

Glenard, who was the first to recognize the clinical significance and importance of enteroptosis, accused the relaxation of the suspensory ligaments of the intestines, especially the one of the transverse colon, of causing, under certain conditions, enteroptosis. Allow me to quote the description of Glenard's disease, as it has been called, from Dr. Einhorn's book: "The whole digestive tract, which from the mouth to the anus is 10 or 15 times longer than a straight line connecting both points, is arranged in the form of different baldachins suspended on six loops, by means of ligaments, at the posterior wall of the abdomen. The zig-zag direction of the loops offers the possibility of too great a bend, sometimes at such an acute angle that it causes obstruction to the passage of the ingesta or secretions at the six main points of fixation. This might occur at the gastro-duodenal, duodeno-jejunal, or transverse, sigmoido-rectal curvatures.

The ligaments are not all of equal length, strength, and the

points of fixation of several of them are especially weak. This is true of the gastro-duodenal, and the transverse colon ligaments. Thus, from a theoretical point of view, it is apparent that the possibility exists that the weak ligaments may give way under favorable conditions, and that a falling of that part of the intestine may result. This would naturally exert an increased traction on the next fixation point, and might cause an obstruction to the passage of the contents of the intestine, or, in other words, a partial enterostenosis. In 40 autopsies, Glenard several times found the colon transversum displaced and stenosed. He recognized that these changes in the anatomical position must give rise to troubles, which should be considered dependent upon this condition. In examining all his patients with digestive troubles, he found that there were many so-called " nervous dyspeptics " in whom he could discover, by a thorough investigation of the abdomen, that some abnormal position of the intestines existed.

He describes the following objective points as characteristic of this affection:

1. Splashing sound.
2. Pulsation of the abdominal aorta.
3. Corde colique transverse.
4. In the right hypochondriac region, frequently movable kidney.

By the term " corde colique transverse " Glenard means the resistance which is found lying over the aorta three to five cm. above the navel, running horizontally six to ten cm. on each side of the median line. This gives the impression of a ribbon one cm. in width, and was supposed by Glenard to be the displaced colon transversum, for pressure on the right iliac region at the beginning of the colon ascendens produced rumbling sounds in the "corde transverse." He consequently concluded that all the symptoms in these patients were caused by this abnormal position of the intestine. He named this condition "enteroptosis."

Glenard's theory was soon attacked as not so generally applicable as was thought when first presented.

Meinert found in 34 out of 100 cases of enteroptosis the right flexure of the colon in its normal condition.

For a long time the corset and the strings with which the skirts are fastened around the waist were said to play an important role in the genesis of the affection, but now their guilt in causing the evil has been adjudged as being only of moderate measure. Just in those cases, which would be most significant to decide this question as to what part the corset and the skirt

strings are playing, in young girls and nulliparæ, it appeared that frequently a tight-fitting corset had never been worn, because it could not be tolerated. Certain it is that tight lacing, tight attachment of skirt strings will aggravate an existing gastroptosis, because the compression of the abdomen from the sides is apt to cause displacement of the right lobe of the liver towards the middle, and thereby to cause pressure on the pyloric portion of the stomach, thus favoring development of gastroptosis.

Now we come to speak of an observation of recent date which merits our attention in a high degree. B. Stiller, of Budapest, found in a large number of nervous dyspeptics, with floating kidney and splashing stomach, that the tenth rib was movable, that is movable to such a degree as normally the 11th and 12th ribs are movable, not being fastened by cartilaginous, but only by ligamentous, structure to the costal arch. He observed that where there is such a floating tenth rib, there is likewise a floating kidney and a displaced stomach. Although this floating rib is not found in every case of enteroptosis, it was never missing in well-pronounced cases. He thinks that the degree of mobility of this rib corresponds with the degree of enteroptosis and the degree of neurasthenia, while the degree of mobility of the kidney does not allow such a condition.

Stiller found children who had floating kidney, with and without a floating tenth rib, and also children with it but without floating kidney and without gastroptosis. He believes, however, that the latter will later on become neurasthenics and enteroptotics.

Stiller further observed that floating rib, nephroptosis and gastroptosis are seldom looked for in patients of advanced years. This fact is explained by the circumstance that the subjective enteroptotic symptoms improve with advancing years, and that people who formerly had consulted the physician on account of neurasthenia would not visit him any more with complaints inviting examination for enteroptosis. This experience that, notwithstanding the existence of enteroptosis, all the manifold symptoms of the disease disappear with years, furnishes conclusive evidence that the dyspeptic and neurasthenic symptoms cannot be attributed principally to nephro and enteroptosis, but are caused primarily by congenital neurasthenia *universalis et gastrica,* which with advancing years lose their grave character.

Stiller sums up: Splanchno or enteroptosis is a descent of the atonic dilated stomach, of the colon, especially the transverse portion, the kidney (the right or both kidneys), exceptionally of

the liver, of the spleen, a descent which has developed mostly in tender age in consequence of general relaxation, especially of the peritoneal suspensory ligaments in individuals with congenital general dyspeptic neurasthenia, tender muscles, lean habit and slender bone structure manifested in the higher degrees by a floating tenth rib.

The question about the relation of typical enteroptosis to all its nervous and dyspeptic attributes and to the well-known picture of nervous dyspepsia has been answered by Glenard to the effect that in reality there is no nervous dyspepsia, since the symptoms are produced by anatomical changes of abdominal organs. Stiller, on the other hand, thinks that enteroptosis is not the primary cause, but only the outcome of congenital atonic conditions. The question of Glenard, whether the fluctuating tenth rib is acquired by the wearing of a corset and other injurious influences, or is congenital, has been answered by Stiller that it is congenital. He bases his answer on the result of autopsies.

Stiller arrives at the conclusion that the floating kidney, whether as a partial symptom or a secondary affection of a general disease, has to be regarded as *noli me tangere* by the surgeon.

We have to congratulate the patients suffering from nephroptosis that the heroic era of extirpation of the floating kidney has passed, but we have to regret yet how often nephrectomy is recommended and executed. I wish to demonstrate here such an unfortunate patient. A patient of mine, a girl, of 14 years, is hereditarily disposed to tuberculosis, since her mother was a victim of this disease. She has exactly the habit of which we have been speaking, the floating rib included. Some colleague proposed nephrorraphy, and the nurses of his hospital, who seem to have acted as agents for the colleague, told heart-rending stories of what would become of her if she did not have the operation performed. Such, at least, was the report given to me. She is doing well now with a proper bandage applied.

Surgical or orthopedic fixation of the kidney can only be of service in cases where other organs are not, or are only slightly involved, which cases are, as we have seen, the exception. We may meet with a woman who has Landau's enteroptosis with descent of the liver and spleen, upon whom the gynecologist has performed ventrofixation of the uterus, and the surgeon nephrorraphy, leaving the field for the neurologist to completely clear up, and such cases are not rare.

Surgical interference should be confined to cases in which torsion of the ureter and other complications give rise to dangerous symptoms.

Stiller calls attention to the relation between the hyperacidity or Reichmann's disease and enteroptosis. Such a relation exists, and in the higher degrees of enteroptosis, hyperacidity is probably always present. The one as well as the other are the outcome of congenital disposition. According to Stiller, the presence of a floating tenth rib may serve in many cases to establish a diagnosis between idiopathic and enteroptotic hyperacidity or of congenital from symptomatic hypersecretion occurring in cases of tabes, myelitis and sclerosis.

In the zeal of classification it has been overlooked sometimes to take into consideration the relation of the different gastric functions to each other and to keep them apart. Prominent symptoms were thus described as special diseases and treated as such. This is the case with hyperacidity which may belong to different morbid processes.

It has to be kept in view that nervous or enteroptotic dyspepsia acts like hysteria, the symptoms are inconstant and changeable; some cases show achylia gastrica, in others acidity is normal; moreover, all these symptoms, previously stated, change about in one and the same case. Here we can say: *Nichts ist bestandig als der Wechsel.*

As we have seen, most cases of nervous dyspepsia are associated with enteroptosis, but, on the other hand, severe forms of nervous dyspepsia have been observed in which there was found a floating tenth rib, but no movable kidney. These cases were apparently those of strong and healthy individuals who acquired dyspepsia either from unknown causes, or after some insignificant enteritic affection, in one case after expulsion of tenia. In these cases enteroptosis of a lighter or severer form will gradually develop, together with which emaciation will set in. It is to be presumed that those individuals also were born with a floating tenth rib, but that they had remained well and strong until suddenly some shock made them a victim of their congenital defect.

A great deal has been written on the relation between anemia and chlorosis *in young girls and displacement of the stomach.* It is certainly rational to assume that chlorosis is not the result of gastroptosis, but the manifestation of a constitutional anomaly which simultaneously favors the disease of the blood and the development of the displacement. There exists chlorosis without gastroptosis, and there is a probability that chlorosis may have been the primary evil causing reduction of tone of the abdominal muscles, and thereby inducing gastroptosis.

A question which is of paramount importance is that of the

relation of gastroptosis to nervous symptoms. These relations are of frequent occurrence, although they are not the same in all cases.

Men afflicted with gastroptosis present symptoms of general nervous irritability less often than do women.

The therapy of gastroptosis consists in the attempt to give tone to the abdominal walls, and if this cannot be attained, to find a substitute for the loss of tone by means of a bandage.

My experience has been scarcely satisfactory with bandages as they are made by the patients or the bandager. Except in Landau cases, it seems difficult to have a well-fitting bandage made. Recollecting how well a broad rubber plaster served me in cases of umbilical hernia when it was cut of the shape of the abdominal wall, tapering off behind, and securing to perfection the whole abdomen; recollecting, moreover, how well such strapping was borne, and knowing of what great service it proves in case of fractured rib, and in some cases of pleurisy, I used plaster of the form and in the manner described in cases of gastroptosis. This practice is only of recent date with me, but in those cases in which I have tried it, the appliance has proved much better than the best-constructed bandages. Especially good results were seen in a case of high degree of gastroptosis in a woman suffering from pulmonary phthisis. The patient had had incessant vomiting and reflex cough; both of these distressing symptoms were relieved by the application of the plaster, and the patient became able to retain food and to digest it, which she had not been able to do for a long time previously.

How well the plaster is borne was shown by the case of a lady in the higher walks of society, to whom I had applied it to relieve the gastralgia remaining after a rest cure for gastric ulcer. This patient wore her plaster bandage for over five weeks, during which time she took her accustomed daily bath. When I removed the plaster, after this period of five weeks, the skin was found in perfect condition.

To strengthen directly the abdominal muscles is a difficult task. Our means for this purpose consist in hydrotherapy, massage, electricity, and gymnastics. Cold douches to the abdomen and sitz baths of short duration have been tried. Massage executed secundum artem in the form of effleurage, petrisage, tapottement in connection with Thure Brandt's *Unternierenzitterwirkung* and faradization of the abdominal walls have also had systematic trial, but the results were unsatisfactory. In some instances these procedures are not harmless, for what we gain on the one hand by invigorating the muscles, we may lose on the

other, by irritating the psyche of an hysterical person. We have to take into consideration that we are dealing with the nervous condition of a patient. More satisfactory results than from these forms of massage mentioned I have seen follow the use of a solid iron cannon ball of five or six pounds weight. This I find is preferable to, because safer, cheaper, more convenient than, energetic massage with the hands. Swimming is an admirable measure. The podylaton, unfortunately called by a would-be Greek word, bicycle, has also been resorted to.

As a prophylactic measure, we should order the abdominal bandage during the second half of pregnancy, and ice-cold compresses immediately post-partum. Of the ice-cold compresses, over the abdomen, after delivery, I can speak in the highest praise, from long experience. They secure comfort, in no case can they do harm, and, indeed, they seem to be the best prophylactic measure at the period indicated to prevent Landau enteroptosis.

DISCUSSION.

PROFESSOR MAX EINHORN said that the paper had presented the subject in a very complete manner. While he knew very well that there existed some cases of gastroptosis, in which the kidney had not slipped down, almost always there would be found associated with gastroptosis, a descent of other organs. For this reason, when Glenard had first described his cases of gastroptosis, some physicians had looked for gastroptosis in order to know when enteroptosis was also present. About eleven years ago he had read a paper before this Society on enteroptosis, and had demonstrated the method of gastrodiaphany as a means of diagnosis. At that time he had made reference to some cases of gastroptosis in which a movable kidney could not be discovered. The most common combination was gastroptosis and right movable kidney. Sometimes both kidneys were movable, but it was decidedly exceptional for a left kidney alone to be movable. Still more rarely was the spleen movable. If the stomach slips down, the aorta is more or less uncovered, and this gives rise to an apparent increase in the aortic pulsation. The reader of the paper seemed to him to lay too much stress upon the gastroptosis. The falling down of the stomach alone would not, he thought, account for the symptoms observed.

With regard to Stiller's symptom he would say, that he could not ascribe much importance to the symptom because Stiller himself had said that he sometimes found cases in which there was a floating tenth rib, and yet there was no movable kidney and no falling down of the stomach. He also found patients

with enteroptosis unassociated with a movable tenth rib. It was perhaps true that a movable tenth rib was found in these cases, but certainly no very great importance should be attached to its presence. He had already published the statement that enteroptosis might exist without any symptoms whatever, yet it must be conceded that many patients affected with enteroptosis did present symptoms. As soon as such persons developed some disturbance of the digestive tract, there was apt to be a longer and more marked disturbance of function than would otherwise be the case. Under normal conditions the organs readily adapt themselves to the changed position. Dr. Rose had spoken against the treating of movable kidney by nephrectomy or nephropexy, and in this respect he agreed. As several of the organs were simultaneously out of place, it was obvious that the sewing of one organ would not remedy the evil. In the great majority of cases of enteroptosis the muscles of the abdomen were weak, and the abdomen was more relaxed than normal. It was, therefore, reasonable to expect relief from bandaging, and in practice this was found to be the case. He had found the abdominal bandage not only of service in those cases of pendulous abdomen described by Landau, but even in those cases in which the abdomen was not pendulous. It was often difficult to make the bandage fit properly, but if the precaution were taken to have a portion cut out over the hips, much of this difficulty would disappear. The suggestion made by the reader of the paper, to apply rubber adhesive plaster, seemed to him a good one, though it was not so pleasant to wear such a dressing. In all these patients, especially if the condition were of long standing, the general health would be found deteriorated. It was of the greatest importance to improve the general nutrition—indeed, the abnormal mobility of the organs would be decreased by this means alone. This was the observation that he had made a number of times.

Dr. Welzmiller said that in the medical clinic they did not encounter many of these cases of enteroptosis. He recalled one case in which there had been a general ptosis of the abdominal organs—the transverse colon, the stomach and the right kidney. The patient was a woman who had borne a number of children. She attributed her difficulty to the omission to wear a binder at her confinements. She had presented certain neurasthenic symptoms, but was chiefly concerned with the cosmetic effect. He had never been satisfied with the diagnosis of gastroptosis alone. The rolling of a cannon ball around the lax abdomen once or twice a day had seemed to him beneficial. The use of

the plaster seemed to him to be likely to weaken rather than to strengthen the abdominal walls.

DR. EINHORN said that Meynert claimed to have found gastroptosis in almost every case of chlorosis, but his conclusions had been based on a wrong method of observation, *i.e.*, undue inflation of the stomach with carbonic acid gas. Instead of giving about thirty grains each of bicarbonate of sodium and tartaric acid he had administered about 120 grains of each, with the result that the stomach had been overdistended and had been pushed downward of necessity. In cases of gastroptosis one found hyperacidity. It was not, however, typical even of gastroptosis, for in many cases the secretion was increased, and in many others it was abnormally scanty.

DR. WILLIAM HENRY PORTER said that, in his experience, he had never met with any of these conditions. In years past he had made a very large number of post-mortem examinations, and did not recall having seen more than two cases in which there had been a displacement of the stomach in either direction. One of these was a case in which the stomach had been displaced up into the thoracic cavity through the rupture of the diaphragm, and along with it there had been a displacement of a considerable portion of the bowel. In another case, one of scirrhus of the pylorus, the stomach had been displaced. None of the abdominal organs were very fixed normally, and hence unless there was a very decided loosening and displacement he did not see how a very accurate diagnosis could be made. Speaking of the splashing sound, he was reminded of another case in which dilatation of the stomach had been diagnosticated. Several opinions had been expressed regarding the case. One physician thought there was impaction of feces at the sigmoid flexure; another thought there was a volvulus at this point; another thought there was a dilated and displaced stomach, the opinion being based upon the splashing sound. The woman's abdomen had been opened over the region of the sigmoid flexure, and the surgeon had found no fecal matter in the abdominal cavity and no twisting of the colon at that point. On passing the hand upward he had found the stomach empty and contracted and crowded up under the liver. The woman had a ruptured transversalis muscle on both sides of the median line, and the small intestine had been displaced out of the abdominal cavity into the new abdominal cavity, so to speak, lying between the transversalis muscle and the oblique muscles. All of her small intestine was outside of the abdominal cavity, and in the new pouch between these muscles. The woman had been in that

condition for over thirty years. Thirty years before, while lifting a heavy washboiler there had been a loud report and a sensation of something giving way in the abdomen, and this strange condition of the abdomen had existed ever since that time. Her abdomen looked more like the buttocks than the abdomen. This had been his whole personal experience regarding such displacements when confirmed by post-mortem examination. He agreed with the previous speakers that the kidney should not be fixed by operation, for the reason that such an operation was liable to subject the patient to what might be called "fibroid Bright's disease." He did not think one had the right to subject the patient to the danger of having a cirrhotic kidney, simply for the purpose of fixing the kidney. He had several patients in whom the kidney had been floating around for some years, and yet with the exception of an occasional sharp twinge, these persons had been as well as if they had not had any floating kidney. Where the muscle had been overstretched and was unable to contract and return to its original position, he believed that if it were held there artificially the muscle fibres would improve in nutrition and would grow stronger. Where the abdominal wall was relaxed there was always a great deal of venous engorgement in the abdominal cavity which greatly interfered with the nutrition of all the viscera. If the abdominal bandage were applied, the pressure on the vessels within would be increased, and in that way this congestion was to a certain extent relieved, and the general nutrition of the individual thereby improved. He believed that without any displacement of the viscera one might observe all of the nervous symptoms and all the secretory disturbances described in connection with gastroptosis. For this reason he doubted if much importance should be attached to such displacements, and if they should be looked upon as distinct affections.

Dr. Rose closed the discussion. He expressed his pleasure at having his opinion regarding nephropexy confirmed by the other speakers. It was true that gastroptosis did not often exist alone, but it was certain that in many cases of enteroptosis it was gastroptosis which gave the main trouble. He would like to ask the surgeons if gastroptosis was improved by operation already referred to; for, personally, he believed that the gastroptosis would perhaps remain where it had been associated with nephroptosis in spite of nephropexy. Stille's symptom was new, and certainly interesting, even though perhaps not of much practical value. It was surprising that this floating rib had been overlooked hitherto, and it remained yet to determine its true

significance. Stille claimed, that although this floating rib was present sometimes without recognizable gastroptosis, it was an indication that gastroptosis would sooner or later develop. His claim was that this floating rib was a congenital condition. Undoubtedly hyperacidity was not constantly present in gastroptosis, though probably present at some stage of the affection in all cases.—*The Post-Graduate.*

THERAPEUTICS.

TREATMENT OF TYPHOID FEVER.

The profession is fairly well agreed on the hygienic treatment of this disease. The dietetic treatment, however, is undergoing some change. Certain eminent physicians, not only in the United States but in Europe, have recently advocated feeding typhoid patients with light or solid food. One physician reports that he has allowed ten patients in succession to have solid food the moment they craved something to eat. Their recovery was uneventful and rapid.

During the course of typhoid, water is needed more than nourishment. Large quantities of water serve to eliminate waste products. The character of the blood indicates a deficiency of water, and patients should be encouraged to drink freely of it whether they ask for it or not. It is well to remember that in this disease the sense of thirst is as much obtunded as that of hunger. The late Dr. John Forsyth Meigs was an enthusiastic advocate of water in typhoid fever, and his graphic description of the disease, in a lecture at the Pennsylvania Hospital in 1879, when he was insisting with great emphasis on supplying water in abundance to typhoid fever patients, is worthy of quotation:

"When I stand by the bedside of a severe typhoid fever, and see the patient motionless, insensible, dead to all the usual senses of the living; when I look at his half-closed eyes, his gaping mouth, his dried and fissured tongue; when I brush the unheeded flies from his poor, unconscious face; and when I touch his hot and burning skin—I ask myself, Into what lower estate can the human body fall? Not only has the patient lost all appetite for food, not only is he dead to all that surrounds him, but his hot and withered body, his dry and pasty mouth, filled with dessicated crusts and sordes, knows no longer even the sense of thirst. This has been the last sense of which he has been deprived. So long

as he retained any consciousness at all he would ask for water or for ice. Now he feels not even this great want. It is in this crisis of his life that he is to be saved, if saved at all, only by the constant care of his physician, nurses, and relatives. And woe to the physician who can look on such a sight and not yearn to know all that his art has acquired through centuries of experience and study."

The fact that the majority of typhoid fever patients will recover on the hygienic and dietetic treatment alone does not justify in every case the withholding entirely of medicinal and other treatment. In another portion of The Journal, the treatment of typhoid fever is most ably discussed by competent authorities. Here we will quote formulæ and methods recommended by other physicians for treating complications, making disinfectants, etc.

DIARRHEA.

Dr. Frederick P. Henry says: "Among the most efficacious means for this purpose are opium suppositories, acetate of lead, gallic acid, nitrate of silver, sulphate of copper, and salicylate of bismuth. Of these drugs I have found the last, in 5-grain powders every three hours, decidedly the best, and this I attribute to its well-marked antiseptic properties."

Dr. J. W. Wilson says: "The preparations of bismuth, as the subcarbonate, subnitrate, salicylate or subgallate, administered by the mouth in full doses and with a frequency dependent upon the urgency of the diarrhea, either alone or in combination with small doses of opium, Dover's powder or deodorized laudanum, constitute in most cases efficient medication; or, again, opium may be advantageously administered in enemata of starch-water or in suppository; or a combination of the aqueous extract of opium and the extract of cannabis indica in suppository may be employed. Such drugs as naphthalin, thymol, and resorcin, supposed to act directly as intestinal antiseptics, have in my experience proved far less useful, while such astringents as alum, plumbic acetate, silver nitrate, tannic acid, catechu, and kino, have only a historic interest. If the stools be highly fetid or ammoniacal, half-dram doses of animal charcoal, in the form of an impalpable powder may be administered in the broth. Creosote and carbolic acid may also be of service."

Notwithstanding Dr. Wilson's opinion of intestinal antiseptics, many able physicians believe them to be efficacious not only in diarrhea and tympanitis, but in shortening the duration of the disease.

In addition to the Woodbridge treatment, which is too familiar to every physician to quote, the following prescriptions have been recommended by various clinicians:

℞ Creosoti carbonatis ..... ℥ xix.
Thymoli ..... ℥ vi.
Mentholi ..... ℥ iii.
Eucalyptoli ..... ℥ viss.
Alcohol, commercial .....q.s. ad ℥ viii.

M. Ft. solutio. Sig.: This is stock solution of carbonate of creosote compound. To make an emulsion from the above, in order to better administer it, use

℞ Creosoti carb. comp., solution ..... ℥ v.
Acaciæ gummi, pulv ..... ℥ iss.
Aquæ pura ..... ℥ iv.

M. Sig.: One teaspoonful every three hours in a wineglass of water, to be followed by a drink of water.—*T. W. Simmons.*

℞ Pulv. carbonis ligni ..... ℥ iii.
Iodoformi ..... gr. xv.
Naphthalini ..... gr. lxxv.
Glycerini ..... ℥ vi.
Carnipepton ..... ℥ iss.

M. Sig.: A teaspoonful every two hours in one-third glass of water.—*Bouchard.*

℞ Thymoli ..... ℥ ii.
Saponis medicinalis .....q.s.

M. Ft. capsulæ No. xxx. Sig.: One every four hours. Or

℞ Thymoli, Guaiacol carbonatis āā ..... ℥ iss.
Saponis medicinalis .....q.s.

M. Ft. capsulæ No. xxx. Sig.: One every four hours.—*Royster.*

℞ Salol ..... ℥ i.
Thymoli ..... gr. xxxvi.
Bismuthi subnitratis ..... ℥ ii.
Mucilag. acaciæ ..... ℥ ii.
Syr. tolutani ..... ℥ iv.

M. Sig.: Tablespoon three times daily.—*Alfred Moore.*

℞ Methylenæ bichloridi ..... ℥ i.
Sol. hydrogen peroxidi ..... ℥ i.
Acidi hydrochlorici dil ..... ♏ xxx.
Aquæ destil .....q.s. ad ℥ vi.

M. Sig.: One-half ounce every three hours in half a tumbler of water.—*B. W. Richardson.*

℞ Naphthol (alpha) ..... gr. iv.
Phenacetin ..... gr. iii.
Pulv. rhei ..... gr. i.
Tinct. cinnamoni ..... ♏ ii.

For one tabloid. One or two six times a day.

℞ Naphthol (alpha) ..... gr. viii.
Bismuthi salicylatis ..... gr. ii.
Pulv. rhei ..... gr. ii.
Ext. belladonnæ ..... gr. ⅙.
Pulv. cinnamoni ..... gr. iii.

In cachet. One four to six times daily.—*Maximowitsch.*

TYMPANITIS.

Dr. Frederick P. Henry says that meteorism is best treated by the application of cold compresses to the abdomen, and by charcoal and alcoholic stimulants internally. These failing, an enema of cold water may induce contraction of the intestinal parietes at the same time as it mechanically dislodges and expels some of the accumulated gas. As a last resort a rectal tube may be carefully inserted and pushed upward as far as possible.

Dr. J. C. Wilson also advocates the use of alcoholic stimulants in this condition. Turpentin or camphor, he says, together with minute doses of opium, may be added to the treatment, and active preparations of pepsin or peptenzyme, alone or together with hydrochloric acid, should be administered with the food. Compresses wrung out of iced water, or turpentin stupes, should be applied, and cautious, gentle massage of the abdomen is also useful. Small enemata of iced water and cold enemata containing turpentin, are sometimes followed by good results.

Dr. Julius Dreschfeld, in "Allbutt's System of Medicine," "advises enemata with turpentin or tincture of valerian. Turpentin may be given internally in capsules of 10 minims. If there be much flatulence, carbolic acid, or creosote, or sulpho-

carbolate of soda (15 grains) may be tried." Hare recommends the following in excessive tympanitis:

℞ Olei terebinthinæ ..... ℥i to ii.
Olei olivæ ..... ℥iv.
Mist. asafetidæ ..... Oi.

M. Sig.: Use as an injection. Shake well before using.

INTESTINAL HEMORRHAGE.

The last-named author advises that hemorrhage from the bowel be treated according to its point of origin, *i.e.*, if in the small intestine, as from ulceration of Peyer's patches or other glands, the medicines must be used by the mouth; if it be from the colon or rectum or from hemorrhoids, medication must be by way of the anus.

"Hemorrhage of the first class," quoting from Hare, "is best combated by the application of a small piece of ice to the belly and by the use of Monsel's salt (ferri subsulphas); 3 grains (0.15) made into a pill should be given every half hour or oftener, the pill being made hard enough to reach the intestine without being dissolved and decomposed in the stomach. The other remedies which are of service are sulphuric acid in the dose of five to ten drops in water in acute or passive bleeding, or turpentin given in capsule, or better still, in emulsion with acacia, in the dose of ten drops every half hour, particularly when the hemorrhage is not active. Acetate of lead and camphor in the following pill may be of service in some cases:

℞ Plumbi acetatis..... gr. v.
Camphoræ ..... gr. x.

"M. Ft. pil. No. v. Sig.: One pill every hour."

Henry believes that ergot administered both *per os* and hypodermically, with application of ice-cold compresses to the abdomen, is about the best treatment.

Wilson believes little can be done for excessive intestinal hemorrhage outside of absolute bodily quiet, and complete withdrawal of food, even water being administered only in small quantities repeated at short intervals, or small pieces of ice; opium internally; cold to the abdomen, and small enemata of iced water, not exceeding four ounces at a time, repeated at short intervals.

Dreschfeld agrees with the authorities mentioned above regarding the use of drugs in intestinal hemorrhage. He recom-

mends the use of acetate of lead, gallic acid, opium, and turpentin, ice to the abdomen, etc. He advises that milk should be stopped or given with carbonate of soda, or in the form of alum whey, that is, mixed with finely-powdered alum and the curds separated from the serum.

Osler says: "Lead and opium pill by the mouth and small doses of morphin hypodermically."

Normal salt solution is injected when there is much loss of blood, and favorable results follow its use in most desperate cases. A fatal result may follow in typhoid fever without blood appearing externally, so we must be on our guard. The following prescription has been recommended:

℞ Benzonaphthol		ʒi¼.	5
Bismuthi salicylate		ʒiiss.	10
Ext. opii		gr. iss.	10
Syr. rhatany, Syr. orange flower	āā	ʒviiss.	30
Mucilage		ʒxxx.	120

M. Sig.: Soupspoonful every half hour.

CONSTIPATION.

Dreschfeld says that constipation lasting only a few days, and not accompanied by much tympanitis and flatulency, need not be treated medicinally; an admixture of beef tea and milk may be tried. If the constipation be more obstinate, glycerin or cold water enemata may be given; should these produce little effect, and the constipation have gone on for five days or more, small doses of castor oil—one or two teaspoonfuls in milk—may be given, and repeated after some hours if necessary.

PERSISTENT VOMITING.

For this distressing symptom, the same authority says, food should be given in small quantities and often. Milk and lime water or some of the prepared foods or cold meat juice with acid.

℞ Bismuthi subnitratis	gr. x.
Cocainæ hydrochloratis	gr. ¼.

M. Ft. chart No. 1. Sig.: A powder this size three or four times a day. A sinapism to the epigastrium may also be applied.

Wilson recommends 1-12 gr. of calomel every half hour or full doses of chemically pure cerium oxalate or of dilute hydrochloric acid. Small amounts of iced dry champagne are also useful, together with applications of a wet towel sprinkled with chloroform or sinapisms to the epigastrium.

INSOMNIA.

Chloral and bromids are undoubtedly the best hypnotics, although paraldehyde, trional, chloralamid and sulphonal are preferred by some physicians because they are thought to be less depressing to the heart.

The writer has never noticed any untoward effects from the administration of chloral, and frequently combines with it small doses of morphia.

DELIRIUM.

Dreschfeld recommends ice to the head, a sinapism to the back of the head, and morphia with quinin; if of low muttering character, stimulants may be given.

Dr. J. C. Wilson also recommends stimulants, and adds that "alcohol stands first and almost alone; spirit of chloroform and spirit of camphor are of use in emergencies, the latter may be administered hypodermically in 5 per cent. solution in ether, of which 10 minims may be repeated once or twice at intervals of several hours, the toxic effects of large doses of camphor being carefully considered. The hypodermic administration of ether alone in 10 minim doses is of advantage. Hyoscin hydrobromate in small doses hypodermically, codein, and suppositories containing asafetida are also useful in the treatment of active delirium, while in cases of hysteroidal delirium the bromids in elixir of ammonium valerianate are frequently followed by good effects."

EPISTAXIS.

Referring to this complication, Dr. Wilson advises "local applications of ice to the nose and brow, an ice-bag to the nape of the neck; the slow instillation into the nostril of very hot water, and the introduction of slender cotton tampons moistened and then rolled in antipyrin or wet with fluid extract of hamamelis, are measures likely to control the bleeding. Should persistent hemorrhage from the nose occur, the anterior and posterior nares are to be plugged with strips of antiseptic gauze.

Dr. Henry says that excellent results are usually produced by the injection into the nares of a solution of alum or tannin, or of pure lemon juice.

BED SORES.

Bed sores can usually be avoided. They are too often an indication of ignorance or negligence on the part of the physician or nurse, or both.

Constant cleanliness and watchfulness, a vigilant eye to dis-

charges, attention to the smoothness and dryness of the sheets, and judicious changes of position, are the secrets of success. All parts exposed to pressure and soiling must, at least twice daily, be washed with soap and water, well dried, rubbed with alcohol, and dusted with powder. A useful mixture is one part boric acid to two of starch. If the skin is inclined to be tender it may be painted with collodion or balsam of Peru and powdered. When it is difficult to maintain dryness, lanolin or zinc ointment may be rubbed in and powdered.

Dreschfeld recommends the following procedure: "If the skin become rough, reddened, or show slight abrasions, the part may be washed with boric acid solution and some ointment, such as zinc or boracic acid ointment, or iodoform powder, may be applied to the abraded part. If a slough have formed, antiseptic and stimulating dressings, such as carbolic acid (1 in 40), or compound tincture of benzoin, or balsam of Peru are required. Over the lint, which ought to fit exactly into the ulcer, a piece of gutta-percha tissue is applied, and outside this again some folds of lint, and the whole fixed by a strip of diachylon plaster. When the slough is large it is best to dust it over with iodoform, or iodol or aristol; this is covered by gutta-percha tissue and over this lint dipped in an antiseptic or stimulating lotion is placed."

TO PREVENT THE SPREAD OF THE DISEASE.

The same authority advises that the following measures be adopted: "The dejections, both urine and feces, are to be received into a bed-pan containing a strong disinfectant—1 to 20 carbolic acid—and a sufficiently large quantity of the disinfectant is to be added to the discharge and well mixed with it. The nates must be well cleansed with paper, or with linen moistened with dilute carbolic acid; this refuse is burnt or added to the contents of the bed-pan. The bed-linen, blanket, and body-linen of the patient should be changed at once when soiled; they should be placed in a sheet soaked in carbolic acid (1 in 40) and afterwards kept for some hours in carbolic acid solution of the same strength; before they are sent to the laundry they should be well boiled. The feeding utensils are to be cleaned in dilute carbolic acid and afterward with boiling water. The nurse, after attending to the alvine discharges or changing the linen, and always before she takes her meals, should wash her hands in corrosive sublimate solution (1 to 1000). Every precaution should be taken after the death of a patient as regards the bed clothing, sheets, etc.; mattresses, pillows and clothes should be sent to a disinfecting oven, when this is feasible.

"Instead of carbolic acid as a disinfectant, some use strong commercial hydrochloric acid or corrosive sublimate. Chlorid of lime is an excellent disinfectant, which quickly destroys typhoid bacilli, and it may be used to disinfect the feces."

"If there be any expectoration, the sputa are to be dealt with in like manner."

The following formulæ are given of well-known antiseptic and disinfectant solutions:

℞ Salicylic acid ..... 1 part.
Boric acid ..... 6 parts.
Water ..... 500 parts.

Mix. Dissolve and filter.

Condy's Fluid:

℞ Potassii permanganate ..... gr. iv.
Aquæ ..... ℥ i.

Mix.

Volkman's Antiseptic Solution:

℞ Thymoli ..... 1 part.
Alcoholi ..... 10 parts.
Glycerini ..... 20 parts.
Aquæ ..... 100 parts.

Dissolve the thymol and the alcohol, add the glycerin, then the water.

Green Vitriol Solution:

℞ Copperas ..... 4 lbs.
Water ..... 2½ gals.

Used for disinfecting bed-pans, closets, etc.

White Vitriol Solution:

℞ Sulphate of zinc ..... ℥ ii.
Carbolic acid ..... ℥ i.
Hot water ..... 1 gal.

Used principally for washing clothing in contagious diseases.

—*The Jour. Amer. Med. Asso.*

USES AND EFFECTS OF GUDE'S PEPTO-MANGAN.

By Dr. Julius Heitzmann, Vienna.

The employment of iron preparations both in essential anemia (chlorosis), and in the symptomatic forms of this affection produced by severe losses of blood, dates from the earliest times. Long before the chemical relation of this effect was known, these remedies were administered on the ground of pure empirical experience.

When Hannan pointed out the high significance of manganese, as well as of iron, with regard to the absorption of oxygen by the blood, and when this discovery was discovered by Ruhle, efforts were made to produce, by combination of both remedies, preparations which would best fulfil the therapeutic indications in all directions.

Former attempts of this kind failed to give the desired results. The aim was to combine both metals in such a form as would enable them to be absorbed throughout the entire extent of the alimentary canal, and at the same time be devoid of disagreeable taste which would prevent their prolonged administration. After a series of experiments made in this direction, I found in the preparation discovered by Dr. A. Gude (Pepto-Mangan—Gude) a remedy which fulfilled the above requisites, and can recommend it most heartily.

Pepto-Mangan (Gude) is a clear, dark, wine red fluid, having an agreeable, non-metallic, astringent taste. The latter property gives it a great advantage over other similar preparations, for the remedy is always taken with pleasure, and may therefore be administered for a long time without exciting the disgust of the patient. No irritation of the stomach is produced, nor is the digestion disturbed in the least respect; indeed, as regards the latter, a stimulation of the long-absent appetite could be demonstrated within a short time.

The Pepto-Mangan (Gude) usually mixed with some water, is prescribed in doses of two or three dessertspoonfuls, increased to as many tablespoonfuls per day. An especially agreeable manner of administration is by addition of cold milk, which then assumes a light chocolate color and an agreeable taste. Prescribed in this form, we obtain from this preparation everything that could be expected from a remedy for anemia. The Pepto-Mangan (Gude) may also be mixed with white and sweet wines,

excepting the red wines which contain tannic acid, and an occasional change in the manner of administration is sometimes of advantage, especially in the case of children.

The diet, during the use of this preparation, should consist of milk, meats—especially ham—fowl, soft-boiled eggs, and other easily digested foods. On the other hand, sour and fatty foods, red wines, and raw fruits are to be avoided.

The remedy is to be administered for a number of weeks, especially in cases of chlorosis, but in the case of young girls up to twelve years of age it is best to commence with a daily dose of two teaspoonfuls (ten grammes). In adults, the dose of the Pepto-Mangan (Gude) may be increased in a few days to one tablespoonful twice or thrice daily, or even to ten or twenty grammes. The preparation should be well protected from the light, and preserved in a cool place in a well-stoppered bottle.

I have employed the Pepto-Mangan (Gude) with much success both in chlorosis and in cases of anemia in girls and women due to loss of blood, menorrhagia, metrorrhagia, inflammation of the pelvic organs, peri- and parametritis, or prolonged leucorrhea. In almost every instance I observed within a short time increase of appetite, improved nutrition, healthier color of the face, and increase of weight. I was surprised to learn how much more readily the Pepto-Mangan (Gude) was taken than similar preparations, without ill effects even after protracted use.

To illustrate my remarks I will cite a few cases:

I will first report a case of chlorosis treated with this remedy, which was under constant observation. The patient, a schoolgirl, aged sixteen, began to menstruate one year ago, but after appearing regularly for three periods the flow suddenly ceased, probably in consequence of mental overexertion, and symptoms of chlorosis soon developed. The various preparations of iron were tried, but were either not well borne or excited so much disgust that they were discontinued by the capricious patient. A milk cure was prescribed, but followed for only a short time. When, however, I resorted to the Pepto-Mangan (Gude) I was surprised to find that the girl took it willingly and that it was well borne. She made a rapid recovery, and after the use of two bottles had regained her former healthy color, while her strength and menstruation returned.

CASE II.—A married lady, aged 24, had acquired—apparently of abortion at a very early period—an intense peri- and parametritis with an exudation of the size of a child's head. The latter disappeared almost completely under suitable treatment and rest, so that only a slight induration was present in the

parametrium after three weeks. Owing to the considerable anemia and loss of appetite, however, the patient recovered very slowly, and for this reason I ordered the Pepto-Mangan (Gude) A few days after its use the appetite reappeared, recovery ensued rapidly, and five weeks later her health was completely restored.

CASE III.—A married lady, aged 30, had suffered from leucorrhea due to catarrhal inflammation of the vagina for two years, and although the local trouble had been much relieved, she continued pale and weak. As her chlorotic daughter at the time was taking the Pepto-Mangan (Gude) with marked benefit, I advised her also to try this preparation. She followed my advice, and after fourteen days the weak, sluggish, and pale woman seemed as if transformed. She has since regained her former health.

These few cases, which were under continued observation, will confirm what has been said above regarding the manner of application and effect of the Pepto-Mangan (Gude). I regard it as superfluous to cite other cases, since a few closely observed cases teach more than a host of superficial observations.

On the ground of my experience I consider myself warranted in directing the attention of physicians to this remedy, and feel convinced that further trials will give equally favorable results. Even in cases where local treatment is necessary, the Pepto-Mangan (Gude) will prove a valuable auxiliary in our treatment.—*Allgemeine Wiener medizinische Zeitung,* xxxvi.

TREATMENT OF ECLAMPSIA.—On account of the remarkably low mortality reported by Knapp in puerperal eclampsia (14.6 per cent.) what he has to say on the subject of treatment ought to be of interest. The first indication is to prevent the patient from self-injury. A wedge of wood should be inserted between the teeth, while at the same time the tongue is drawn forward in order that it may not obstruct the glottis. Other injuries, such as those likely to arise from collision with bed, should also be guarded against. Nevertheless, no attempt should be made to oppose the convulsive movements by force. Special attention should be directed to the state of the pulse and respiration, since dyspnea and cyanosis constitute alarming symptoms. The main indication for treatment is to neutralize the convulsivant poison, which, as has been stated, appears to be analagous in its action with strychnia. Thus far we have no antidote or antitoxin at our disposal, and our only resource is to get the noxious substance eliminated, and so prevent cumulative action. An ener-

getic diphoresis is strongly indicated. Zweifel has devised a "sweating bed" to meet this want. The hot pack and hot bath are simply applications of the same principle. For a number of years, the use of the physiological solution has been a bulwark in our treatment, securing as it does both diuresis and diaphoresis. It is useless to employ ordinary medicamentous sudorifics and diuretics. Since the convulsions depend upon exalted excitability, narcotics may be used, rather as adjuvants than in massive doses. Veit is a firm believer in morphia, and claimed a series of sixty-six consecutive recoveries from eclampsia by the use of this substance. He even asserted that no one should lose a case of eclampsia. The results of others do not bear out this claim. The combined chloroform-morphine narcosis, judiciously applied, may be of value, but Duhrssen has shown that the narcotic plan of treatment predisposes to broncho-pneumonia and cardiac degeneration. Since narcosis is indispensable in connection with the obstetrical operations for evacuating the uterus, the use of this class of substances for the convulsive paroxysm may be regarded as a secondary one. We never know how many convulsions may occur, and it is probably the wiser course not to depend upon narcotics at all as anticonvulsivants. Whatever benefit may accrue from a cautious use of this class of remedies may be looked upon as legitimate. Two important symptomatic remedies are stimulants (camphor and ether hypodermically) for heart-failure, and venesection for congestion. Knapp mentions veratria (veratrum viride) as an empirical remedy of value. The use of oxygen-gas and artificial respiration is also of value. He finds that the treatment of puerperal eclampsia corresponds with that of strychnine poisoning to a considerable extent. It goes without saying that the whole art of the obstetrician must be directed to emptying the uterus as rapidly as possible. In the author's cases premature delivery was induced three times, the forceps were applied in sixteen cases, and in eleven cases mutilating operations were performed. Natural labor occurred five times. Knapp in some cases hastens the first stage by intra-uterine colpeurysis and incision of the cervix. In one case the cervical wounds bled profusely and required immediate suture after forceps delivery. It is apparent that forceps delivery, whenever readily effected, constitutes a favorable element in prognosis; of the author's sixteen cases, only two were lost, although a number of the survivors exhibited evidence of infection. The infantile mortality was equally small. In fact, the operative mortality of mothers was but 8.6 per cent. Knapp agrees with Duhrssen that Cæsarian section is contraindicated

in eclampsia; the mortality from this operation is high. In conclusion, Knapp insists with Veit that cases must be treated individually, that more or less benefit may accrue from the narcotic plan of treatment, and that the necessity for the more radical forms of operative interference (perforation, Cæsarian section, etc.) must as far as possible be avoided.—*Obs.*

THE UNIMPORTANCE OF THE PRESENCE OF A TRACE OF ALBUMEN OR NUCLEO-ALBUMEN IN URINES OF EXTREMELY LOW SPECIFIC GRAVITY.—F. Parkes Weber, M.D. (*Brit. Med. Jour.*, Jan. 6th, 1900), thus delivers himself on this subject: I will at once explain that by "urines of extremely low specific gravity" I here refer to urines of practically the same specific gravity, when freshly passed, as ordinary tap water. The urinometer sinks to zero, but when the urine cools it may rise a degree or so. In the case of a "limpid urine" of this kind I believe that no conclusion of any value for diagnostic purposes can be drawn from the detection of a "very faint trace of albumen." The test for albumen which I have regularly employed in these cases is to boil the upper part of the column of the urine in a test-tube, and to add a few drops of acetic acid. When there is a faint but distinct cloudiness of the boiled portion (the two portions being compared with each other against a dark background), one may conclude, I think, that a trace of albumen or nucleo-albumen is present, for I do not see that the reaction can be due to anything else. Some would even say that nucleo-albumen by itself cannot give rise to the reaction. Anyhow, the presence of such "a trace" is of very frequent if not of usual occurrence in urines of extremely low specific gravity. I will take an illustrative case of ordinary occurrence. About midday, a man hurries from his work in the city to an insurance office, and is examined by the medical officer of the company. The applicant feels somewhat nervous; moreover, he may have had no time for lunch, and on the way to the insurance office takes perhaps a small glass of whisky and soda-water with a sandwich. When he presents himself for examination, the doctor probably finds the pulse rather frequent from excitement and hurry, the heart's action may be forcible, and there may be even a temporary systolic murmur, though possibly only of cardio-pulmonary nature. If in such a case I find the urine nearly colorless and the urinometer sinks down to about zero, I almost expect to find a very faint trace of albumen (or nucleo-albumen) by employing the common and, as I believe, the most generally

useful test, that is, the test which I have previously mentioned. Has not this man got chronic interstitial nephritis? The urine is of extremely low specific gravity, and apparently contains the very faintest trace of albumen; the heart's action is somewhat violent. Moreover, if the specific gravity of the urine were higher, the "trace" might become a regular "cloud." In many such cases the breath of the person under examination has a faint but distinct smell, as if he had just had some alcoholic drink; but very little alcohol will produce this smell in some people, especially if taken on an empty stomach. I maintain that no positive conclusion of any diagnostic value can be drawn from the examination of the urine in such cases, not even that alcoholic drinks are frequently indulged in. It seems, in fact, that in healthy persons, under certain more or less temporary conditions, a urine is passed containing hardly any of the ordinary solid constituents, but a faint trace of albumen or nucleo-albumen. In some very different cases, when the urine is of high specific gravity and loaded with urates, a trace of albumen may be discovered, which disappears when, by alteration of diet, etc., the urine becomes of lower specific gravity, and free from precipitate on cooling. These two classes of urine may be contrasted with each other. In the latter class the kidneys, when overworked (from a variety of causes) allow a trace of albumen to pass, together with large quantities of urea and uric acid salts. In the former case, under some temporary influence, a large quantity of urine is passed containing a faint trace of albumen, or nucleo-albumen, but hardly any urea or urates or other solid constituents.

TREATMENT OF GASTRIC ULCER.—Saunby, in a clinical lecture on ulcer of the stomach, delivered at the General Hospital, Birmingham, and published in the *British Medical Journal,* Jan. 20, 1900, delivers himself thus: "It is a rule which I would commend to your attention that in the management of stomach disorders obstinate vomiting should be treated by absolute rest in bed and the administration of the simplest food in small quantities at regular intervals. I generally prescribe 1 ounce of milk and lime water every hour with the following mixture:

Sulphate of magnesium	40 grains.
Sulphate of iron	2 grains.
Diluted sulphuric acid	15 grains.
Peppermint water to	1 ounce.

three times a day. The milk and lime-water, if borne without pain and vomiting, as is almost invariably the case, is increased every day or every second day up to 4 ounces every hour, and afterwards the diet is gradually increased by the addition of bread and milk, minced chicken, and minced mutton at intervals, so that about twenty-one days after admission the patient is usually able to eat the ordinary house diet of the hospital. After this has been taken for two or three days, the patient is allowed to get up, and at the end of a month is sent to a convalescent home. When the anemia is marked, the mixture may be supplemented by pil. ferri, 5 gr. or more three times a day. Should the patient not be able to tolerate so much milk and lime-water in the first instance, half an ounce may be given, or if there be only pain without vomiting, a mixture of bismuth and soda may be substituted for that of iron and magnesia. In those cases which have recently suffered from hematemesis, it is desirable to give nothing by the mouth until forty-eight hours have elapsed after the vomiting of blood has stopped, and during that time I feed them by the following nutrient enema, given every four hours: One egg beaten up with one teaspoonful of brandy, and made up to 4 ozs. with milk. Should there be any irritability of the rectum, twenty to thirty drops of laudanum may be added. While the hematemesis persists, I place an ice-bag upon the epigastrium, although I am by no means certain that it does any good, and I allow the patient to suck small pieces of ice if she wishes. If necessary to relieve pain or to keep the patient quiet, I order a hypodermic injection of 1-6 to 1-3 grain of morphine. It is of great importance to see that the patient is able to eat ordinary food with comfort before she leaves the hospital, and I always try to impress upon each one the importance of continuing to do this after she returns home. Many of these patients have been dieting themselves for so long a time, and have become convinced, partly as the result of injudicious advice, partly from their own experience, that they cannot eat the same food as other people, that they have suffered in health from an insufficient nutrition,and have entered a vicious circle in which the anemia is kept up by want of food, so that the predisposing cause persists, and recovery is impossible until the circle is broken; it is therefore of the utmost importance to prove to your patient that she can take ordinary food. It is also very desirable that she should continue to take iron for some time after leaving the hospital; and I may perhaps be allowed to mention that the dose of sulphate of magnesium in the mixture should be adjusted to the needs of each case, and may be very properly increased or

diminished at different times as required. These simple rules are all that I wish you to remember in connection with the treatment of ulcer of the stomach, and I hope I have proved that they are as safe as they are successful."

SPLENIC ANEMIA.—Dr. B. W. Sippy (*American Jour. of Med. Sciences,* Oct.).—Only a very limited number of cases have been recorded, and only recently has the disease attracted much attention. A man, aged 45, went to hospital. He had always enjoyed good health until three and a half years previously, when he noticed a swelling in the left hypochondrium, and became easily fatigued and short of breath. He complained of slight nausea, vomited occasionally, lost appetite, and suffered from diarrhea. Then he became rather constipated and now and then had chilly sensations, followed by fever. Epistaxis began two years previously and often recurred. The feet became swollen a month previous to examination. The tumor in the left side gradually grew. He lost about twenty-five pounds in weight, and could walk only a short distance without experiencing fatigue and dyspnea. There was a slight sub-icteric hue of the skin and conjunctivæ. The mucous membranes were pale. The inguinal glands were slightly enlarged. The lower limbs were edematous to within a few inches of the knees. There was slight edema of both wrists. The spleen was greatly enlarged, extending to within two fingers' breadth of the pubes. The liver was enlarged, extending to within 1 1-2 inches of the umbilicus. Splenic leukemia was diagnosed, but examination of the blood showed that the diagnosis was not correct. There were 1,740,000 red and 5,214 white corpuscles per cubic millimetre; the hemoglobin was 30 per cent. The leucocytes showed the following relations: Polynuclear neutrophiles, 66.4 per cent.; eosinophiles, 10.8 per cent.; transitional forms, 3 per cent.; large mononuclear, 4 per cent.; and small mononuclear or lymphocytes, 25 per cent. Splenic anemia was therefore diagnosed. The patient was kept in bed, and iron, arsenic, and bitter tonics were given. Pallor and edema gradually increased and ascites appeared. Death took place at the end of four months. At the necropsy the spleen weighed 5.2 lbs. The section was red, firm and uniform. Microscopically, the reticulum of some of the Malpighian corpuscles was increased, and a few showed considerable sclerosis. The liver weighed 6.2 lbs.; there were slight increase of the interlobular connective tissue and marked infiltration of lymphoid elements. Splenic anemia shares in the general obscurity sur-

rounding the allied disease of leukemia and the other varieties of pseudo-leukemia. The splenic enlargement appears to be the primary change and the anemia secondary, for the former in all the reported cases has preceded the latter, in some for the period of a year. Moreover, recovery has taken place in five cases after splenectomy. Medical treatment appears quite unable to arrest the fatal progress of the disease.—*The Med. Rev.*

THE BONE LESIONS OF TYPHOID FEVER.—Ch. Achard, (in *La Semaine Medicale,* October 18th, page 345). The discovery of Eberth's bacillus has enabled two kinds of osteomyelitis, following typhoid fever, to be distinguished. One is not directly related to the typhoid bacillus, but is produced by the ordinary pyogenic organisms, staphylococci, or streptococci, as a secondary infection. Boils are frequently the source of the organisms. The other variety is due directly to the typhoid bacillus. It is not very uncommon, and has special clinical characters which resemble closely those of syphilitic nodes. The first symptom is pain of variable intensity, increased by pressure, but limited to a definite spot on one of the bones, often the tibia or a rib. After a time the pain diminishes, and a swelling on the bone forms a circumscribed tumor of doughy consistency. This may soften still further in the centre, which may even fluctuate while the peripheral part becomes more thickened. Incision shows vegetations resembling granulation tissue, with purulent or serosanguineous fluid usually in small amount. The non-purulent fluid appears to be formed in the earlier stage, and generally contains Eberth's bacillus in pure culture, but the pus is often sterile, apparently, because of the death of the organisms. Therefore, in favorable cases, spontaneous resolution is possible, the pus becoming absorbed after the death of the bacilli, and the bony swelling being reduced to a simple exostosis. In other cases, there is severe and localised pain without appreciable swelling of the bone. Here, probably, there is a small and deep focus which remains latent, and undergoes spontaneous resolution. Again, the more or less diffused pains in the bones following typhoid fever may be ascribed to irritation of the bone marrow due to the presence of Eberth's bacillus, which has been found there in fatal cases, or to its toxins, which have been experimentally shown to produce a reaction in the medulla. The diagnosis is usually simplified by the occurrence of these symptoms during convalescence, or soon after recovery from typhoid fever, but even then they have been mistaken for syphilitic or tuberculous

lesions. The detection of Eberth's bacillus or a positive serum reaction is diagnostic. The more diffused pains require no special treatment, but where a localised inflammatory change exists it may require surgical intervention, as spontaneous resolution, when it takes place, is very slow. Those which suppurate are best treated by removing, as completely as possible, the whole focus, which is generally small. There is usually no reason for early operation, except in the rare cases of acute onset, as the slow development of the lesion allows the patient to regain his strength without extension of the process.—*The Med. Rev.*

KOPLIK'S SIGN.—It has been well said that, in the exanthemata, "diagnosis should never be made upon the rash alone." This dictum involves a severe comment upon the methods which for lack of laboratory aids, are forced upon us in the diagnosis of these affections. If diagnosis should not be made upon the rash, it cannot certainly be made without the rash. Before the period of eruption one cannot even be sure that an eruptive fever is in process of invasion, and diagnosis must be more or less random guesswork, while diagnosis on the appearance of eruption is sadly belated. These hours and days of conjecture are dangerous, and extraordinary interest attaches to any new means of early diagnosis. The appearances of the visible mucous membranes in the various eruptive disorders have been long studied, and are described in all the text-books. It remained for Henry Koplik to discover and to describe, in 1896, a lesion of the buccal mucous membrane, which is said to be associated only with measles, and in a majority of instances to precede the skin eruption by a considerable interval. It is likely that Flindt made the same observation some ten years earlier, but the phenomenon is now properly associated with the name of the later observer, who, discovering it independently, has been able to impress its value upon his contemporaries. The results of a special inquiry upon this subject are found elsewhere in the present number of the Journal, and a partial analysis, following as nearly as possible the language of the witnesses, follows: Of the twenty observers, six characterize the sign by the word "pathognomonic"—Hirsh, Libman, Lichtenstein, Ross, Sobel, Zahorsky. The sign is diagnostic when present, according to seventeen observers—Adriance, Blackader, Blanton, Cheney, de Saussure, Gilbert, Hirsh, Libman, Lichtenstein, Mitchell, Morse, Ross, Sobel, Taylor, West, Zabriskie, Zahorsky. These three doubt its diagnostic value—Adams, Cameron, Cotton. Absence of the spots excludes

measles, according to seven observers—Hirsh, Libman, Lichtenstein, Ross, Sobel, West, Zabriskie. Absence of the sign does not exclude measles, five observers—Adams, Cameron, Cheney, Morse, Zahorsky. The sign has been observed in advance of the eruption by thirteen—Adriance (twenty cases out of ninety-six), Blackader (in every case), Cheney ("frequently"), Gilbert, Hirsh, Libman, Lichtenstein (as early as three days before the eruption), Morse, Mitchell (forty-eight hours before the eruption), Ross, Sobel (from a few hours to five days before the eruption), West, Zabriskie, Zahorsky.—Edit. *Md. Med. Jour.*

SPEECH AS A SEPTIC INFLUENCE.—George Fox, the founder of the Quakers, who looked upon smoking as a grievous sin, justified his condemnation of it by the words of St. Matthew: "Not that which goeth into the mouth defileth a man; but that which cometh out of the mouth, this defileth a man." If Professor Flugge were given to similar eccentricities of exegesis, he might quote the same text in support of the doctrine which he preaches that speech is a means of distributing disease germs. He has shown that from the mouth of a person who is speaking come bacteria contained in little bubbles of saliva, which after remaining suspended some time in the air are scattered through the surrounding atmosphere. Hubener has made experiments on the subject. Placing a man at a distance of 50 cm. from four agar plates, representing a total surface of 200 square centimetres, he made him to count aloud for ten minutes. During that time from 100 to 1,500 germs, expelled from the mouth of the speaker, were deposited on the plates. Hubener draws from this fact the practical inference that a surgeon explaining the steps of the procedure during an operation might infect the wound by means of the germs expelled from his mouth in the act of speaking. To guard against this source of sepsis he has constructed a sort of filter consisting of a metal cage covered with gauze. This apparatus, which covers the mouth and nose, is fixed to the ears like spectacles. Not long ago Hubener raised his voice in warning as to the infective possibilities of the surgeon's beard, and recommended that ornamental appendage to be enclosed in what may be called a bacterium net. One may conjure up a prophetic vision of the twentieth century surgeon with antiseptic mass, beard-bag, gloves, and sterilized robe, operating within a glass sanctuary into which no one is admitted except after the fullest disinfectant lustration. But Flugge's doctrine has a much wider application than he has indicated. If speech has these hitherto

undreamt-of dangers for the audience, Parliamentary and public orators will have to wear germ-catching muzzles; this, besides protecting their hearers, will doubtless have the further advantage of making their eloquence less copious as well as more sanitary. Society would find in the same sanitary appliance an effective safeguard against bores.—*British Medical Journal.*

TREATMENT OF SCABIES.—In the *Journal of Cutaneous and Genito-Urinary Diseases,* November, 1899, Sherwell emphasizes the use of sulphur powder in scabies. He recommends the washed flowers of sulphur, and believes it to be the cleanest, least disagreeable and the most efficient method of treatment. He directs that the patient first take a bath at night with soap (sapolio is recommended); the body and limbs are then rubbed lightly with a little sulphur lotion. Powdered sulphur is scattered between clean sheets. The patient thus bathes every night, the bed is powdered with sulphur every second night, and the wearing apparel is changed frequently. Thus in seven to nine days the case is cured. Sherwell asserts that he has never seen a dermatitis nor failure of cure with the method.—*Maryland Medical Journal.*

INHALATIONS OF FORMALDEHYDE IN CATARRHAL AFFECTIONS.—P. Beristain proclaims in the *Cronica Med. Mexicana* the extreme efficacy of inhalations of formaldehyde in catarrhal affections of the upper air-passages, due to its superior disinfecting power, and its ability to penetrate even through thick layers of liquids. It destroys the pathogenic germs and suppresses the cause of the irritation, leaving the field free for the restorative action of nature. All his patients thus treated have been relieved from the first, and cured in a brief space of time. The generating lamp is placed in a metal box with a cover easily removed. The patients inhale the fumes at intervals, during ten to fifteen minutes.—*Jour. Amer. Med. Asso.*

YOLK OF EGG AS EXCIPIENT FOR SALVES.—Unna is now using a salve composed of two parts yolk of egg to three parts oil of sweet almonds, blended as for a salad dressing, to which is added the medicinal substance required, to a proportion of ten per cent. The salve dries rapidly and forms a protecting covering especially advantageous in eczema, acne and scabies. One per cent peruvian balsam will prevent decomposition.—*Jour. Amer. Med. Asso.*

MONTHLY REPORT.

Issued March 21, 1900,
P. H. BRYCE, M.A., M.D., Secretary.

Issued by the Provincial Board of Health of Ontario for February, 1900. Showing the deaths from all causes and from Contagious Diseases in the Province, as reported to the Registrar-General by the Division Registrars throughout the Province.

YEAR.	MONTH.	Total population of province 2,283,182	Total municipalities of province, 777.	Total deaths reported from all causes.	Rate per 1,000 per annum from all causes.	Scarlatina.	Rate per 1,000 per annum.	Diphtheria.	Rate per 1,000 per annum.	Measles.	Rate per 1,000 per annum.	Whooping cough.	Rate per 1,000 per annum.	Typhoid.	Rate per 1,000 per annum.	Tuberculosis (Consumption).	Rate per 1,000 per annum.
1900....	February	Total population reporting 2,205,266 97%	Total municipalities reporting 720 93%	1,962	10.6	14	0.07	39	0.2	7	0.04	3	0.01	13	0.07	186	1.0
1899....	January	2,057,455 90%	638 82%	1,771	10.0	13	0.07	51	0.3	2	0.01	4	0.02	16	0.9	183	1.6
1899....	December	2,276,532 99.7%	756 97%	1,843	10.0	20	0.09	42	0.2	3	0.01	6	0.02	28	0.1	157	0.8

YEAR.	MONTH.	Total population reporting.	Total municipalities reporting.	Total deaths reported.	Rate per 1,000 per annum from all causes.	Scarlatina.	Rate per 1,000 per annum.	Diphtheria.	Rate per 1,000 per annum.	Measles.	Rate per 1,000 per annum.	Whooping cough.	Rate per 1,000 per annum.	Typhoid.	Rate per 1,000 per annum.	Tuberculosis.	Rate per 1,000 per annum.
1900....	February	2,237,882 98%	725 93%	2568	13.7	32	0.1	35	0.02	2	0.01	3	0.02	16	0.08	215	1.1
1899....	January	2,232,053 98%	717 92%	2154	11.2	23	0.1	48	0.3	5	0.03	9	0.05	21	0.1	184	1.0
1898....	December	2,173,906 96%	687 88%	237	....	10	0.06	51	0.3	2	0.01	12	0.07	21	0.1	141	0.8

DOMINION
MEDICAL MONTHLY

AND ONTARIO MEDICAL JOURNAL.

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VOL. XIV. TORONTO, APRIL, 1900. No. 4.

THE UNIVERSITY OF TORONTO—THE PROVINCIAL UNIVERSITY, AND THE MEDICAL COLLEGES.

Dr. Angus MacKay, M.L.A., South Oxford, has precipitated an animated and important campaign on Medical College matters by the introduction, into the Local Legislature of the Province, of a Bill, most vital in its import (1) to the University itself, (2) to the Medical Colleges, and (3) to the Medical Department of the University. We take it that any legislation affecting the integrity and status of the Provincial University should be considered in the broadest and most liberal manner possible; that no bias nor partizanship, in every application of the term, should have any place in the discussion of this proposed legislation. If the Provincial University is to profit by this proposition, then all the friends thereof must divest themselves of all animus and personal interest, in order that what is just and right and fair may predominate. If it will redound to the glory and distinction of the Provincial University to have its Medical Department, as suggested by Dr. MacKay, re-constructed

so as to embrace within its jurisdiction all of the teaching Medical Faculties of the entire Province, instead of one alone, as at present constituted, the real friends of the University will be found working towards that end; those who place themselves in opposition to the scheme will be its enemies, either knowingly or unconsciously. To be truly provincial in character, the University should not antagonize large sections of the community or even place these sections in the anomalous position of exercising no thought nor care nor interest in its welfare, though indirectly contributing towards its maintenance. Whether will it be better for the interests of the Provincial University to have one special Medical Department working alone for its advancement and preferment, or to have all the Medical Colleges of the Province contributing their quota towards its welfare? The answer to this question seems so plain that it scarcely needs confirming affirmatively. It will certainly not abolish nor take away from the University the interest that the present Medical Department has in its future, but it will rather add to that interest by supplementing thereto friendliness, enthusiasm, and zeal—an increment of interest and co-operation from the other Medical Colleges now excluded from participation therein, from the fact of being practically ostracized as regards any voice or say in the government of the Provincial University as at present constituted. Can the Medical Department of the University as it at present exists—the "rump," so one of the learned professors of that Faculty would have the public believe, of the old Toronto School of Medicine—can the Medical Department fairly lay the charge at the doors of Trinity Medical College, that the latter are the true self-seekers in this campaign? Surely, the Medical Department of the University of Toronto cannot deny to Trinity Medical College or any other Medical College in the Province the right to take a proper interest in the welfare of the Provincial University. Shall Trinity Medical College and all other Medical Colleges in the province, aggrieved and wronged since 1887, continue to labor and lie under these disabilities because the Medical Department, as at present constituted, may be flourishing? Is the Medical Department afraid to put itself upon equal footing with the others, or must it continue to suckle at the public crib? There is nothing in the proposals of Dr. MacKay that will militate against the future aggrandizement of the Provincial University. The Provincial University will continue to have a Medical Department, truly provincial in character, truly representative in every particular and truly worthy of the great University which Trinity men as well as Toronto men would see grow and prosper

The abolition of the special favored Medical Department now existing surely does not mean the total extinction of that teaching Medical Faculty. Substituting a more liberal, a more representative, a more provincial Medical Department, of which the present Medical Department would constitute an integral part, does mean that the Provincial University would be in every respect worthy the name.

There is another side of the question which has not as yet been put strong enough, and that is from the standpoint of the student. Have all the students of the respective Medical Colleges in the Province equal right with the students of the Medical Department of the Provincial University in presenting themselves before the Examining Board of that Department? Are they on equal footing in writing on these examinations set in the great majority of the papers by teachers on a rival faculty to their own? Would they have the same confidence in themselves when they presented themselves in the oral examinations, for instance, as the students who had been intimately associated with their teachers, either in the lecture halls or in the wards of the hospitals at bed-side clinics? Unhesitatingly, the answer to these three questions must be, No. A student, for instance, coming from the Medical Department of the Western University at London. having had no lectures from these examiners, is manifestly at a disadvantage, because he is not in touch either with the examiner's methods and knows nothing of the important points this examiner has been in the habit of inculcating as a teacher. In the matter of choice where he is to prepare himself for the practice of medicine, is his own business, and if he elects to enrol himself on the register of either Kingston, London, or Trinity Medical College, that fact should act as no barrier in preventing him having equal rights before the examiners of the Provincial University. At the same time, any Government privileges accorded his friend who elects to register with the Medical Department of the Provincial University, should in all fair sense be accorded to him as well. We doubt not there is a good deal of truth in the assertion that many of the students at the various Medical Colleges of the Province would be glad of a fair opportunity of presenting themselves annually at the University examinations, but for the disabilities under which they lie in this respect, and that by permitting these disabilities to exist and remain, the authorities of the Provincial University are pursuing a short-sighted financial policy, and thus keeping out of their needy coffers many good valuable dollars. In this manner and in this way alone should the proposed legisla-

tion be looked at—its advantages to the Provincial University, and its rights to the medical student. Judging from the reports and interviews in the daily papers, all of which we think we have read intelligently and carefully, one would think that Trinity Medical College had much to gain and the Medical Department of the University much to lose. The mean lies between these two extremes, viz., legislation which will redound to the advantage of the Provincial University, and doing what is just and right by the poor student who has to face these examinations and covets the degree. All that has been said pro and con for the legislation can thus be put tersely: Don't hurt me; don't give Trinity any favors. Give all students equal rights at the Provincial University.

OBSTACLES TO LABOR RESULTING FROM OPERATIVE FIXATION OF THE UTERUS.

Ludwig Kleinwachter is the author of a really interesting and valuable monogram dealing with the operative treatment of uterine displacements, which also discusses the complications arising throughout pregnancy and labor after such operative procedures. The work is based upon the results achieved from 301 observers. Passing over the various operations for the rectification of the posteriorly displaced uterus, as the condition more commonly demanding operative attention, the Alexander-Adams method of dealing with this displacement of the uterus is the one most frequently performed, although modified in different detail by many well-known and expert operators. From various sources the author has collected the reports of 112 pregnancies after this operation; and of these he states that eleven or 9.82 per cent., were delivered before term. Of the balance, 101 who were delivered at term, one alone had abdominal pain. Forceps were used twice; version was performed once for a transverse presentation. Retained placenta and post-partum hemorrhage were recorded in but one case. From this record, one is able to gather that leaving out the enhanced tendency to abortion, there has been very little increase in the frequency of complications, no more perhaps than would occur in normal pregnancy.

Taking up the other frequently-performed operation for this condition, ventro-fixation or gastrohysteropexy, it has been found that the greatest obstruction in ventro-fixation occurs

where the uterine body has been fixed at a higher place upon its fundus to a comparatively low point on the abdominal wall. There have been many cases of pregnancy following this operation reported from time to time in the medical press, that there has been no comparative difficulty in arriving at the usual results in these cases. The frequency of pain at the site of the operation is put down at 21 per cent., due no doubt to stretching of the adhesions between the uterus and the wall of the abdomen. One observer has noted that difficulty of urination is a symptom, commonly seen in about 16 per cent. of the cases. Then excessive vomiting during the course of the pregnancy is not uncommon.

After the onset of labor, inefficient uterine contraction is a common factor present; whilst there have not been a few who have noted that early rupture of the membranes is very often present with accompanying prolapse of the cord. In 179 pregnancies, one observer used the forceps 11 times; and the author of the monogram referred to has collected 18 other forceps operations from the literature. Another authority puts the frequency of forceps at 9.8 per cent., and believes that transverse presentations are frequent.

In those cases where the fundus has been fixed low down to the symphysis pubis, when pregnancy developed, it has been observed that the cervix was displaced upwards and backwards, thus rendering the usual obstetrical operations difficult of performing. The author has collected eight cases of Cesarean operation in these cases. These two operations he considers advisable or justifiable in women who expect to conceive after the operation; and that the operations of vagino-fixation, and vesico-fixation should not be performed during the child-bearing period of life.

Editorial Notes.

THREATENED INVASION OF BUBONIC PLAGUE.—The fact that a number of cases of bubonic plague have made their appearance in San Francisco has given the U. S. Marine Hospital Service—the sanitary watchmen of that country—no small amount of alarm. Dr. Kinyoun, of this service, who is the highest living authority on epidemic diseases, was called to the Pacific Coast, and verified by post mortem and bacteriologic examination that the disease was true bubonic plague, and urged the most rigid sanitary measures. There can be no question that this disease

is the most frightful and rapidly fatal of all contagious diseases. The mortality rates of smallpox, typhus and yellow fever sink into insignificance compared with that of bubonic plague. One epidemic in Constantinople caused ten thousand deaths in one day. In Bombay there were recently over one hundred and sixty thousand deaths within a very short time. Out of sixteen hundred cases in Hong Kong, there resulted fifteen hundred and forty-one deaths. Such a disease is truly to be prevented from gaining a foothold in this country. The specific organism of bubonic plague is conveyed mostly by shipping. This organism was discovered independently by Versin and Kitasato in 1894, since which time there have been constant efforts on the part of bacteriologists to produce a prophylactic, either in the form of a serum or vaccine. These investigations have met with the most successful results. Haffkine, a leading scientist, prepared a vaccine which has robbed the plague of its terrors. Barker and Flint, of Johns Hopkins University, compiled statistics of the plague cases in Manila, which show that the mortality in the unvaccinated is seven times greater than in the vaccinated. With their usual scientific enterprise, the H. K. Mulford Company, of Philadelphia and Chicago, have fitted up a separate laboratory for the preparation of Haffkine's plague vaccine, and are shipping large quantities of it to the Orient. The laboratory in which the plague vaccine is prepared is several miles distant from their antitoxin and vaccine laboratories. We have just received a valuable pamphlet from the Mulford Company that contains a concise and complete description of the cause, development, symptomatology and prevention of Bubonic Plague. It is particularly valuable now at the time when the disease has placed the entire sanitary corps of the Government on the alert. The pamphlet, we believe, is sent free by the Mulford Company to all physicians requesting it.

News Items.

DR. COOK, of Chesley, is moving to Toronto.

THE Manitoba Insane Asylum is over-crowded.

DR. SHEARD will spend three weeks' vacation in New York.

ANOTHER trial of an osteopath will shortly take place in Toronto.

MONTREAL is talking of erecting a new civic hospital at a cost of $50,000.

DR. HARRY PEARSON, Trinity, '95, is on the road for Davis & Lawrence.

AN anti-vaccination meeting in Victoria, B.C., a few weeks ago, broke up in a free fight.

THE Sisters of the Hotel Dieu, Montreal, are contemplating the erection of a new hospital.

DR. D. J. GIBB-WISHART has been appointed Laryngologist to the Gravenhurst Sanitarium.

MCGILL advertises a post-graduate course in Medicine from May 1st, continuing six weeks.

THE Toronto Clinical Society will hold their annual banquet on the 18th April, at Albany Club.

DR. R. S. MINNES, Ottawa, has been elected a member of Queen's University Council, Kingston.

LORD STRATHCONA has contributed $2,000 to the Normal School of Domestic Science, Hamilton.

DR. C. D. PARFITT has purchased the practice and residence of Dr. G. Silverthorn, Gerrard Street East.

THE Medical Health Officer has been asked to prepare plans for a new smallpox hospital in Riverdale Park.

DRS. CHARLES SHEARD and L. M. Sweetnam have been appointed consulting physicians to the Gravenhurst Sanitarium.

DR. P. J. L. BISSIONETTE, M.L.A. for Montcalm, has been appointed a member of the Provincial Board of Health of Quebec.

SIR WILLIAM MACDONALD has bestowed the magnificent sum of $200,000 on the Chemistry Department of McGill University.

DR. SHEARD has reported unfavorably upon the chosen site and building for the proposed consumption hospital in North Toronto.

DR. FUTGER, house surgeon T. G. H. in 1895, will commence practice in Toronto, he having severed his connection with Johns Hopkins.

DR. J. G. LAMONT, Brantford, Ont., was in the city on the 11th inst. looking up some of his old classmates while at Trinity, '91 to '95.

THE grippe has been very prevalent in Montreal for the past two months. It is of a mild type. German measles continues to haunt Toronto.

IT is understood that the Provincial Government is considering the advisability of establishing a laboratory at the Gravenhurst Sanitarium.

DR. "WADDY" THOMPSON, Waubashene, has disposed of his practice to Dr. Frank Porter, late of Toronto, and will reside in the city hereafter.

DR. T. D. REED died last week at the Royal Victoria Hospital, Montreal. He was Professor of Materia Medica and Dean of the Montreal Pharmacy College.

THE Trinity Medical Alumni will banquet on the evening of the conferring of medical degrees, at Trinity University. The Temple Cafe will be the scene of the reunion.

MONTREAL is contemplating the erection of a civic sanitarium for consumptives, probably on the top of Mount Royal, although this site has been objected to on account of its proximity to the city.

THE Commission appointed by British Columbia to inquire into the state of the Insane Asylum at New Westminster, has reported that everything is well managed and conducted in that institution.

DR. T. B. RICHARDSON, Carlton St., was married on the 3rd inst. to Miss Anna Coad, only daughter of the late Richard Brook Rutland. Congratulations from the DOMINION MEDICAL MONTHLY.

DR. D. C. MEYERS was married at St. Catharines on the 24th of March, to Miss Edith Alexandra, only daughter of the late Rev. George Burson. The DOMINION MEDICAL MONTHLY begs to tender its congratulations.

THE Canadian Military Institute has passed a strong resolution urging the Government to equip and despatch at once a field hospital to South Africa.

LONDON, Ont., General Hospital management has been coming in for considerable criticism at the hands of the local press on account of non-employment of the children's pavilion and the bicycle costumes of nurses and others.

AT the recent session of the Provincial Legislature of the Province of Quebec, the City of Montreal secured special legislation, providing for a more efficient regulation of the registration of births, and also for the appointment of a milk inspector.

SMALLPOX is now under good control in New Brunswick, and is practically at an end. The disease, however, continues to progress in the lower part of the Province of Quebec, where several new cases are reported to have broken out in Paspebiac, Bonaventure Co.

MRS. Fleming, who has been matron of the civic hospital, Montreal, for the past three and a half years, left that city last week for Cape Nome, Alaska, where she has been offered and accepted the management of a large hospital now nearing completion at that place.

AT the Protestant Hospital, Ottawa, on February 28th, there were in residence, 92 patients. During the month of March there were 106 admissions. There were 86 discharged cured, 23 relieved, and 10 died. There were 79 in residence on the 1st of April. This hospital was never so largely used as at present.

THE National Sanitarium Association has issued a very favorable report of the work accomplished during the hospital year, 1898-1899. Dr. J. H. Elliott, the Medical Superintendent, is at present in Europe, and has received an appointment at the hands of the Liverpool School of Tropical Diseases to proceed to West Africa to study malaria.

AT the General Hospital, Montreal, 248 patients have been admitted during the month of March. 279 have been discharged. The average daily number has been 176, the largest number on any one day being 190. There were 24 deaths recorded during the month. In the out-door department, 4,165 minor operations and consultations were attended to; and there were 94 ambulance calls during the month.

THE following have been appointed on the new Home for Incurables, St. John, N.B.: Consulting Physician-surgeons, Drs. Wm. Bayard, Boyle Travers, John Berryman, Jas. Christie, P. R. Inches; and H. G. Addy. Visiting Physician-surgeons, Drs. W. F. Roberts, F. W. Daniel, Murray McLaren, T. D. Walker, and S. S. Skinner. *Oculist,* John H. Morrison; *Dermatologist,* Dr. Melon; *Pathologist,* W. L. Ellis.

THE following is the list of graduates at Queen's University in Medicine for 1900: D. M. A. Allison, Adolphustown; T. J. Barnet, Clayton; D. B. Bridge, Westbrook; S. Burton, Kingston; R. F. Carmichael, Strange, Ont.; E. W. Donnelly, Cataraqui; J. W. Edwards, Kingston; C. C. Ferrier, Kingston; W. A. Hall, Kingston; F. R. Hastings, Kingston; R. C. Hiscock, Kingston; C. P. Johns, B.A., Kingston; T. H. Johnston, Drayton; A. McConville, Kingston; R. D. W. Parker, Bermuda; S. E. Porter, Lindsay; W. S. Broderick, Ottawa; T. F. O'Hagan, Fort William; W. J. Ross, Martintown; S. M. Smith, Kingston; T. A. Wilson, Kamloops, B.C. Prize-winners, recommended for house surgeons: T. H. Johnston, B. B. Bridge, R. C. Hiscock, C. P. Johns, R. F. Carmichael. *Medal for Surgery:* T. H. Johnston, of Drayton, with the honor of medal in medicine. *Medal in Medicine:* B. B. Bridge. Faculty Prize of $25 for the best examination in Anatomy, Physiology and Chemistry: T. O. MacLaren, of Lancaster. Dr. Hayunga's prize for the best examination in Materia Medica, $10 in books, G. F. Dalton, B.A., Kingston.

Physicians' Library

Surgical Pathology and Therapeutics. By JOHN COLLINS WARREN, M.D., LL.D., Professor of Surgery in Harvard University; Surgeon to the Massachusetts General Hospital. Illustrated. Second edition, with an Appendix, containing an enumeration of the Scientific Aids to Surgical Diagnosis, together with a series of Sections on Regional Bacteriology. Philadelphia: W. B. Saunders, 1900. Canadian Agents: J. A. Carveth & Co., Toronto. Price, $5.00, cloth; $6.00 Sheep or Half Morocco.

There is scarcely a doubt that this is the best work extant on Surgical Pathology, a branch of surgical science now forming an important feature of the medical student's cur-

riculum. Surgical pathology is a delightful study, and every one ought to be up to date in its newest and latest advances. For this purpose we can recommend no better work, which reflects unusual credit upon its eminent and talented author. The old appendix has been eliminated and a new one added. The aim of the author in this has been to present in a practical manner the resources of surgical pathology. "In addition to an enumeration of the scientific aids to surgical diagnosis, there is presented a series of sections on what may be termed regional bacteriology," and in this is given the general principles of treating the affections as well as the flora of the affected parts, which produce these affections. Altogether, the work will meet with the demand its merits deserve.

Progressive Medicine—Volume I., 1900. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE, M.D., Professor of Therapeutics and Materia Medica in Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 404 pages, 36 engravings and a colored plate. Philadelphia and New York: Lea Brothers & Co. Issued quarterly. Price, $10.00 per year.

A year's experience with "Progressive Medicine" seems to show that no more helpful enterprise has ever been presented to the medical profession. Useful as Year Books have been, this publication eliminates their faults by presenting its matter in a digested and readily assimilable narrative form.

As in the older method, every available source is culled for material, but in *Progressive Medicine* only the gist is given, and statements are modified, weighed, and their true value suggested by the author in charge of each department.

The scheme of *Progressive Medicine* as carried out last year has proved to be so excellent that no material alteration has this year been found necessary. In a few minor matters some changes have been made, for instance, greater attention has been paid to Therapeutics—prescriptions have been quoted when necessary, etc.

It may be invidious to refer to special portions of the present volume (Vol. I., March, 1900), but the reader will not fail to be struck with the excellence of Dr. DaCosta's references to diseases of the mammary gland (page 67); Dr. Packard's careful investigation into serum-therapy in diphtheria, and his authoritative

statement, summing up the concensus of opinion as to the Brand method of treatment in typhoid (page 155).

Dr. Blackader's contribution to the corresponding volume last year, on Pediatrics, was one of the features of the series, and his chapter this year exhibits the same painstaking, practical qualities. The articles on pathology, on diseases of the larynx, and on diseases of the ear, and, in fact, the entire contents of the volume will be found up-to-date, practical, and of the utmost value.

REPRINTS RECEIVED.

"Studies on Internal Antisepsis." By EDWIN KLEBS, M.D., Munchen, Germany.

"Stricture of the Esophagus and Electrolysis by a New Esophageal Electrode." By CHARLES D. AARON, M.D., Detroit, Mich.

Correspondence.

To the Editor of DOMINION MEDICAL MONTHLY:

DEAR SIR,—At a meeting of the Victoria Medical Society, held March 16th, 1900, the following resolution was moved and carried: "That the Secretary be instructed to write DOMINION MED. MONTHLY. thanking the editor for his encouraging article upon our action *re* lodge practice, but informing the editor that we are sorry to tell him that two of our members, viz.: Drs. Ernest Hall and Joseph Gibbs, after signing the agreement, promptly violated it, and are now doing the combined lodge work of the city, and in consequence have been expelled from membership in the Victoria Medical Society. I remain,

Yours truly,

HERMANN M. ROBERTSON,

Victoria, B.C., March 19th, 1900. *Sec. Vic. Med Soc.*