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TORONTO, DECEMBER, 1879.

Selections: Medicine.

BRIGHT'S DISEASE.

The sixth International Congress of Medical Science was held in Amsterdam during the week from September 7th to September 13th.

Bright's Disease.—The following note was presented to Section 1—that of Medicine—at the discussion on Bright's disease, by Professor Semmola of Naples. It comprised a *résumé* of the communication made by Dr. Semmola to the International Medical Congress at Brussels, on different kinds of albuminuria, which was reported in the *Gaz Méd. de Paris*, 1875; also a *résumé* of further researches made by Professor Semmola, and communicated to the present International Congress of Amsterdam. He said:

1. My first researches were conducted as far back as 1850. I think that I was the first to show the classic influence of alimentation and diet on the quantity of urine which is secreted in Bright's disease. (See Jaccoud's work, *Manual of Internal Pathology*, Paris, 1873, vol. ii. p. 685.)

2. This influence of diet on the increase or decrease of albumen in the urine, according to the greater or less amount of nitrogenous elements in the food, was the starting-point of all my researches. It led me to conclude that it is absolutely necessary to direct our attention not only to the renal lesions, but also to general nutritive disturbances in which the albuminoid bodies are either not at all, or only imperfectly, assimilated and consumed.

3. This idea, which I have always endeavoured to develop concerning the etiology of Bright's disease, has, to my mind, been confirmed by another classical fact which has hitherto remained completely misunderstood. I mean the considerable and progressive decrease in the quantity of urea which is formed in the organism from the first stages of chronic Bright's disease. (See note at the end.)

4. I have always insisted on this classical and fundamental point, and have repeatedly made communications on the subject to the Académie de Médecine of Paris and to that of Naples. I especially insisted on this point in Paris (1867) and in Brussels (1875), and have convinced myself by the study of three hundred clinical cases that the decrease of the urea from the first stages of Bright's disease is owing to a defective oxidation of the albuminoid matter.

I find that in all books authors speak of the defective excretion of urea; but I have never yet been able to discover anything about the defective formation, which I am sure is a principal and fundamental fact; a characteristic phenomenon of Bright's disease.

It is caused by the total or partial absence of the cutaneous functions. In consequence of this suppression of the respiratory functions of the skin, two chemical disturbances arise, which are closely united from a biological point of view—viz., the alteration and inassimilability of the albuminoid substances, and defective combustion, *i.e.*, a decrease in the formation of urea. I leave it to experimental physiology to elucidate the part which the cutaneous functions play in the assimilation and combustion of albuminoid matter. I shall merely restrict myself to pointing out the intimate connection between the two which has been revealed by the pathological condition; and I foresee that it will lead to the solution of a problem which is of great import-

ance both for physiology and pathology. As I have said before, this is a capital and fundamental fact, that can be repeated experimentally by varnishing to a certain extent the skin of a dog. It proves that the real chronic Bright's disease is a general affection, a defect in nutrition, in which the changes that take place in the kidneys (beginning with hyperæmia and ending with cirrhosis and atrophy) do not constitute the primary cause of the principal symptoms of the disease. Physiology fails to explain by what mechanism a morbid process, which has been confined to the kidneys from its very beginning—that is to say, at an epoch when they still fulfil their duty as purifying apparatus—could have had any effect on the production of urea, and thus act on the whole system. I beg my honourable colleagues to direct their attention to this point of renal pathology. It is a most important point, that has hitherto remained unobserved, because it can only be studied in the first stages of the disease, which only in rare cases come under notice in hospitals and clinics.

In all other cases of albuminuria that are not instances of true Bright's albuminuria, this decrease in the production of urea which runs parallel with the increase of albumen is not found. Consequently, it is of the highest importance to distinguish carefully between these different kinds of albuminuria so as to avoid a mistake that is often made and is dangerous, both clinically and therapeutically. The cause, the mechanism, the evolution, in short the *cachet* of the general chemical process of nutrition, combined with the decrease in the production of urea, and last but not least, the pathological alterations which take place in both kidneys, form a harmonious *tout ensemble*, which is always the same and constitutes the true type of Bright's disease properly so called.

6. The decrease in the production of urea which takes place in other cases of albuminuria is not in any way connected with albuminous filtration. It may exist in some cases, but varies very much according to the particular disease that has produced the albuminuria, and at the same time created disturbances in the general process of nutrition (heart-disease, etc.). Here, however, the decrease in the production of urea is not connected with the phenomenon of albuminuria; its progress takes place in an entirely different way, and it is not till the last stage of those various affections, *i.e.*, when the kidneys have become thoroughly diseased (amyloid degeneration, etc.), that a very considerable decrease takes place in the secretion of urea in the urine for want of filtration. It results from the aforesaid, that this decrease is a mechanical effect which gives rise to the accumulation of urea in the blood with all its fatal consequences.

7. In Bright's disease, properly so called, there are two causes for the decrease of urea in the urine. In the first stage of the disease, the decrease is caused by incomplete combustion, a defective nutrition, combined with changes in the albuminoid, which is gradually developed, owing to the suppression of the cutaneous functions. Later on, that is to say, when the affection of the kidneys has reached a further stage, a second decrease of the urea takes place in the urine owing to defective secretion.

8. The tendency to exaggerate the anatomical point of view of the affection has led to neglect of the chemical and more universal aspect of it, thereby producing a conclusion which is perfectly paradoxical so far as regards scientific pathology, *i.e.*, "clinical unity" and "anatomical plurality" (large white kidney, amyloid degeneration, etc.). It is impossible to perceive in what way a general alteration, which shows itself with the same symptoms and consequently must spring from the same causes, can bring forth different anatomical results. The final difference in the lesion shows that there has been a difference in the nature of the preceding morbid processes. By combining all the conditions under which the symptoms constituting the clinical aspect can exist, the successive evolution of the process, and the constant relation between it and its special causes, we shall succeed in reconstructing the edifice of true Bright's disease, and in distinguishing it as a peculiar pathological species which differs from other species of albuminuaia.

9. The passages of albumen into the urine may take place through the three physiological factors that preside over the renal functions; viz., *a.* chemical constitution of the blood; *b.* degree of pressure; *c.* condition of the histological elements of the filtering apparatus.

10. Consequently, there are three classes of albuminuria, viz.: *a.* dyscrasic albuminuria (caused by excess of presence of the albuminoid constituents of the blood or by alterations occurring in them); *b.* mechanical albuminuria; *c.* albuminuria produced by irritation, *i.e.*, by some local histological cause existing in the kidney. This species is caused by the irritating effect of all the agents that penetrate into the kidney, either from without or that are formed in the organism.

These three classes of albuminuria are closely related to different anatomical conditions of the kidney. If each one of these three conditions have been only transitory, the anatomical structure of the kidney may remain in its normal condition an no albuminous filtration will take place (as in series *a.*). In other cases, it may be modified by a transitory morbid process, and then regain its previous normal condition. Finally, if the pathological condition that has given rise to albuminuria be presistent, the anatomical structure of the kidney undergoes a gradual change, and causes a particular defined lesion which differs according to the cause, and is in relation with each of the three factors which have modified the renal function so as to determine the filtration of the albumen. This will be more clearly shown in the diagram which follows:

DIAGRAM OF CLASSES OF ALBUMINURIA.

Variety of Albuminuria.	Causes.	Condition of Kidney.	Urea in the Blood and in the Urine.
a. Chemical conditions of the blood. Dyscrasic albuminuria.	Presence in the blood of an excess of albumen, owing to the diet.	Normal kidney.	The maximum of urea, sulphates, and phosphates contained in the urine varies according to the individual.
	An excess of the albuminoid constituents of the blood, owing to defective combustion.	Irritative hyperæmia, which is more or less intense according to the organ or apparatus whose functions are affected: the cutaneous surface, lung-disease, etc.	Progressive decrease of the urea in the urine, though it is not accumulated in the blood. Want of production.
	A change in the chemical constitution of the albuminoid bodies which circulate in the blood. This change renders them incapable of being assimilated, etc. (cachexia).	Fatty degeneration. Amyloid degeneration.	*Idem*, owing to the gravity of the case which causes cachexia.
b. Degree of pressure of the current of the blood. Mechanical albuminuria.	Various neuropathic affections having a direct or indirect effect upon the vaso motor system.	More or less transitory renal stasis.	Amount of urea almost normal, within the limits of physiological oscillations.
	Pregnancy: in short, every kind of pressure exercised on the inferior vena cava or the renal veins.	*Idem*, but occasionally the stasis becomes permanent, owing to the general conditions of the organism, or to organic causes that produce the lesion.	Amount of urea not depending on the pregnancy or the organic causes that produce pressure.
	Cardiac diseases that have not yet reached the stage of compensation.	Persistent stasis, cyanosed kidney, cardiac kidney.	Amount of urea decreases in proportion as the affection of the heart increases.
c. Histological alterations take place in the kidneys. Irritative albuminuria.	All the irritative processes in the kidneys, from their first stage up to complete nephritis. The albuminous filtration is more or less considerable in proportion to the *rôle* and effect that the inflamed elements may have in the mechanism of the urinary filtration.	All the anatomical consequences of inflammation beginning at the first stage, and the degeneration of the different kinds of epithelium up to renal sclerosis and atrophy. This depends on the special histological seat of the inflammation and its particular course.	Amount of urea is normal or slightly increased, owing to the fever (acute stage). Decrease in the production of urea, though there is no increase in the blood, owing to general disturbances in the combustion. Decrease in the production of urea, owing to defective filtration, and consequently accumulation in the blood.

If we look at the clinical history of Bright's disease properly so called, with a view to classifying it among one of the preceding groups, we find that it cannot be placed exclusively under either of these heads. It is a mixed albuminuria, *i.e.*, its complicated etiological mechanism contains all the other three mechanisms of the other classes of this affection. Analysed in this way, Bright's disease reveals a constant evolution and a harmonious relation between the nature of the cause, the etiological mechanism, the chemical and anatomical alterations, and the clinical form. The *modus operandi* is as follows: *a.* The gradual effect of moist cold on the skin. The gradual action of moist cold is the only cause of true Bright's disease. Other causes produce albuminuria and lesions that differ from the true type. *b.* The respiratory functions of the skin decrease gradually, till they cease completely. Their absence gives rise to the following disturbances, which appear at the same time, and are closely connected with each other: 1. Cutaneous ischæmia; 2. Accumulation in the blood of matter which ought to have been excreted by the skin; 3. Alteration of the albuminoid bodies, so that those which originate from the peptones are not assimilated; 4. Decrease in the combustion of the albuminoid bodies, and consequently in the production of urea.

If it were possible to arrest for a moment the harmonic solidarity of all the organs and apparatus, the kidneys might be excluded, as it were, for a certain time, during which first period they would be in no way connected with the true pathology of Bright's disease. But a similar abstraction can only be conceived in order to show that the anatomical lesions of the kidney are only a secondary process, and do not constitute the initial lesion of Bright's disease.

The four aforesaid causes produce the following effects upon the kidneys:

1. Renal hyperæmia. (Increase of pressure).

2. Irritating effect of the said hyperæmia, owing to the accumulation in the blood of substances that ought to have been excreted by the skin, and its dyscrasic condition in consequence. (Inflammatory effects.)

3. Elimination of the albumen through the kidneys (the depuratory organs *par excellence*), because, the constitution of the albumen being altered, owing to paralysis of the skin, it has become an useless substance, and may almost be regarded as a foreign body in the organism.

4. The progressive decrease of the urea in the urine is the result of the decrease in its production.

Thus we have a twofold series of effects, that are closely connected with and complement each other, *i.e.*: 1. The general nutritive lesions, with all their characteristic consequences; 2. The anatomical development of the inflammatory process of both kidneys, from the first stage to the last. These two series of disturbances constitute Bright's disease, or Bright's albuminuria.

The differences which exist in the clinical form of other albuminurias, and the combination of various final anatomical lesions existing in the same kidneys, depend entirely on special etiological causes (alcoholism, gout, syphilis, etc.), which modify the general condition of the individual, and consequently add to the renal lesions that are peculiar to the inflammatory chronic process other elements that vary according to either the nature of the alteration, or to their seat being more or less confined to one or the other of the different histological elements which constitute the kidneys. It follows that true Bright's disease has nothing to do either anatomically or clinically with any of the other species of albuminuria, whatever may be their origin. I also believe that it is not at all true, though affirmed by several authors, that Bright's disease may be caused by alcoholism, gout, etc. Whether considered from a scientific or a practical point of view, this appears false; because it is a well-known clinical fact that there is such a thing as albuminuria caused by gout, alcohol, etc. And each one of these affections corresponds to general nutritive alterations, which differ not only according to their etiology, but also are represented anatomically by considerable alterations in the kidneys, which in some cases are due to nephritis. These alterations, however, vary very much, so far as regards the affected spots; sometimes they are restricted to one kidney alone (embolic nephritis, pyelitis, stone, syphilis, etc.). If

both kidneys be affected, we always find that there exists a secondary disease, in which predominates an inflammatory condition either of the elements of the parenchyma or of the connective tissue, and which is either due to the irritating effect of a foreign body that passes through the kidneys (alcohol, resinous matter, cantharides, etc.), or to the presence of a deposit of urea that irritates and inflames the neighbouring tissues. In cases of degeneration (fatty, amyloid, etc.), the kidneys are as much affected as many other organs (liver, spleen, etc.); and it would be absurd to regard these cases as belonging to Bright's disease. I repeat it again and again, I am justified by my researches in concluding that true Bright's disease is a constant clinical type, a pathological specialty the characteristics of which *intra vitam* are albuminuria, absence of urea, cachexia, and a peculiar anasarca. The anatomical changes consist in an inflammatory process of both kidneys, which progresses very slowly, and extends gradually over the whole of the organ. These changes, however, are not quite the same for all the elements of the kidneys, but differ according to the physiological part that each element plays in the discharge of the renal function. All the exclusively histological localisations that have been held up as special forms of Bright's disease do not exist in nature in an isolated condition. They may only predominate in some elements that are more affected than others. That this renal affection is always a bilateral one I have already mentioned. I believe that this constant bilaterality constitutes, from an anatomical point of view, the peculiar characteristic or the final control of true Bright't disease, thereby adding a new proof to what I have said, viz., that there exists a profound universal deterioration of the system, which precedes the outbreak of the disease, and must necessarily act on both kidneys at the same time, though with characteristic slowness.

According to my opinion, this constant renal alteration ought alone to be called "Bright's kidney," for the following reasons, viz.: It is caused by the effect of moist cold; the dyscrasia following it is of a particular nature; and finally it develops gradually from a simply hyperæmic state till it becomes atrophic. It may occasionally reveal somewhat different symptoms; but this only takes place when another cause (alcoholism, gout, etc.) is superadded to the action of moist cold. Thus we have a series of complicated effects, both in the clinical form *intra vitam*, and in the nature of the alterations which are found in the kidneys and other organs after death.—*British Medical Journal.*

ON THE GENESIS AND PREVENTION OF TUBERCLE AND TUBERCLE-ENGENDERED DISEASE.

BY HENRY MAC CORMAC, M.D., BELFAST.

The laws of nature are certain and irreversible. It is undoubted that a ceaseless tissue-change ensues in man and animals; that old materials are given off and replaced by new; that nitrogenous waste is got rid of by the kidneys mainly, carbonaceous waste by the lungs mainly. A process of slow combustion takes place incessantly throughout the organism. The carbonaceous waste unites with the oxygen of the incoming breath, and is discharged ceaselessly, as carbonic acid, with the outgoing breath. So long as this process is performed efficiently and without interference, tubercular deposits are impossible. But when the same air, in whole or in part, is breathed again habitually, the effete carbon is not sufficiently oxidised, and of necessity accumulates in the organism. Tubercle, he submitted, is no other than the retained, because unoxidised, carbonaceous waste. Carbonaceous waste is never retained, tubercle never forms, unless when air already breathed proves more or less the unwholesome pabulum of respiratory life. These positions he assumed to have abundantly demonstrated in his treatises on consumption. If the members of the profession were but universally aware that air only once respired will not sustain combustion, they would not, he thought, gainsay his position that pre-respired air will not sustain life; and that consumption and scrofula, when fatal, are but forms of slow death, coupled with the corollary that, by making people breathe day and night air not rebreathed, consumption and scrofula, with all their hateful train, might be interdicted and set aside for ever.—*Brit. Med. Jour.*

(Translated for the CANADIAN JOURNAL OF MEDICAL SCIENCE.)

CONTRIBUTION TO THE STUDY OF ERYSIPELAS OF THE RESPIRATORY PASSAGES.

BY M. L. STRAUS,

Physician to the Hôpital Tenon.

The ancients, from Hippocrates down to Van Swieten and Borsieri, attributed a very great *rôle* to what they called *internal erysipelas,* and greatly dreaded erysipelatous metastases and repercussions, when, at the commencement of the present century, the works of Bichat and of Pinel directed attention to the numerous similitudes, anatomical as well as pathological, between the mucous membranes and the external tegument, so far at least as the mucous membranes holding the relation of direct continuity with the skin were concerned, this doctrine seemed to find in these works a fresh confirmation. Such was not the case, however. Compromised by its very excesses, the doctrine of internal erysipelas found but little favour with the anatomical school, and Behier was, as it were, the last echo of the opposition when he refused to see, even in erysipelas of the pharynx, any thing else "than an erysipelas complicated with angina, or an angina complicated with erysipelas." The question is, however, now set at rest; and thanks to the researches of Gubler, Lailler, Ed. Labbè, Cornil, Ciure, and Lasegue, it has been resolved, not absolutely according to the ancient conception of metastasis, but in the sense of the more rational theory of propagation by continuity of tissue, erysipelas of the nasal fossæ, of the mouth, of the pharynx, is now an accepted fact, no more to be disputed. The existence of *erysipelas of the respiratory passages* is also solidly established since the researches of Gubler and the remarkable theses of Lailler and Ed. Labbé. It must however be admited that these cases are infinitely rarer than those of guttural erysipelas, and perhaps rarer still are the published cases. M. Schlumberger in an excellent thesis, written under the inspiration of Cornil in 1872, was able to find in the whole literature of the subject only 6 or 7 cases, one of which was recently recorded in the service of my colleague, M. Dujardin Beaumetz. These cases nevertheless amply suffice to establish the indubitable existence of erysipelas of the larynx, trachea and bronchi. Quite otherwise is it with *erysipelatous pneumonia* or erysipelas of the lung. The ancients who admitted its existence without discussion and greatly feared it did not establish its reality by any anatomical proof. Since the question of erysipelas of the respiratory passages has been restated on a new foundation, no case anatomically demonstrated, nor any decisive clinical observation has been published. It has been my fortune to observe, and to follow from day to day, a case which I may be permitted by anticipation to designate by the name of *erysipelatous pneumonia* or more properly *erysipelas of the lung.* The conditions under which this pulmonary lesion occurred in a subject effected with erysipelas of the face, and of the buccopharyngeal cavity, its course and special evolution, its anatomical and histological characters, will, I think, justify this interpretation. (Here follow the clinical details of the case and the autopsy, which being too long to reproduce here we pass on to the conclusion of the paper.)

Let us sum up the principal features of this observation. A young man of vigorous constitution, not addicted to alcohol, and unaffected by any previous serious illness, enters the hospital on the 15th of March, for an erysipelas of the face which runs its course unmarked by any notable peculiarity. Six days later, the erysipelas being almost extinct upon the face and the patient nearly convalescent, there appeared dysphagia, with bright redness of the pharynx, uvula, tonsils and tongue (buccopharyngeal erysipelas); no hoarseness of the voice or laryngeal symptoms. On the 23rd of March there occurred violent recrudescence of the fever, acceleration of the pulse, and slight pain in the right side without a chill, slightly marked cough. A pneumonia spread with extreme rapidity, and in less than 4 days it had invaded the right lung throughout from base to apex, without presenting at any point a tendency to resolution. High fever, (the temperature being maintained above 40°c. morning as well as night) of an adynamic type existed, with meteorism, epistaxis, and subicteric tint of skin. The pneumonia appeared on the 23rd of

March, and on the 28th the patient was dead. *Histologic examination of the lung.* This examination furnishes in my opinion, new and decisive arguments in favour of the *special* nature of the pneumonia to which this patient succumbed. Even microscopically the appearance of the lung, on section, presented this peculiarity, namely, that in spite of the total and massive hepatisation, the pneumonic granulations were but slightly marked, even in the upper lobe in the portion affected with red hepatisation. The seropurulent liquid, which flowed in abundance from the surface of section, examined under the microscope, contained pus globules and red blood corpuscles, but no fibrinous mould of the terminal bronchioles and infundibula, as is observed in the liquid obtained by scraping the section of a lung affected by acute pneumonia after methodical hardening (alcohol, picric acid, gum), microscopical examination shewed the pulmonary alveoli completely filled by leucocytes *without any trace of fibrin.* On removing with a brush the leucocytes which filled the alveoli, the latter appeared with their proper contours, and it was impossible to detect the presence of swollen, multinuclear epithelial cells as is done in catarrhal pneumonia. Even the trabeculae of alveoli and the interlobular septa (lymphatics ?) are also deeply infiltrated by pus globules. The total absence of fibrine is observed not only in the portion of lung in full grey hepatisation but also in the portions affected with rose or red hepatisation.

It remains for us now to discuss this observation and its real value, and to establish that we had not to do with a simple pneumonia occuring in an erysipelatous patient, but with something special, in a word, with erysipelas of the lung. Now, this pneumonia presents clinical peculiarities, and above all anatomical peculiarities which distinguish and specialize it.

Clinically, there is in the first place the fact of the supervention of pneumonia in a subject affected with facial and guttural erysipelas, in the absence of any appreciable causative influence, imprudence or chilling; let us note, besides, the insidiousness of the inception, marked by a slight pain in the side, without chill, and lastly the extremely rapid and extensive march of the disease (the whole right lung being invaded in four days). The anatomical peculiarities are more decisive. The propagation by way of the trachea and right main bronchus is evident, and, it seems to me, sufficiently removes the objection of conicidence; no doubt the intermediate step, the erysipelas of the larynx and of the mucous membrane covering the upper rings of the trachea, is wanting. We must admit, either that the larynx has been over leaped by the erysipelatous phlegmasia, or that this latter has been so light and fugacious in this region as to leave no vestiges on the cadaver. The enormous extent of the solidification, its so rapid and entire passage to grey hepatisation in a young, vigorous and non-alcoholic subject are also worthy of attention.

Lastly, histologically, the total absence of fibrin in the pneumonic exudation is a point whose importance will escape no one. Doubtless when acute pneumonia has reached the stage of grey hepatisation the exudation is dislodged and liquefies, and the fibrin is dissolved in part but never in totality. Here, on the other hand, I repeat, this absence of fibrine was equally observed in the points of red hepatisation. One cannot refrain from comparing the enormous infiltration of the pulmonary alveoli by leucocytes, observed in this case, with that which occurs in the derma in cutaneous erysipelas. We know, in fact, since the labours of Vulpian, of Volkmann and Stendner, and of J. Renaut, cutaneous erysipelas is especially characterised by an abundant issue of leucocytes occurring into the meshes of the derma in the neighbourhood of the vessels and lymphatics. This vehement eruption of leucocytes is effected here into the pulmonary alveoli, doubtless by an anologus mechanism, and certainly under the influence of the same cause, the erysipelatous agent. In the two determinations of the erysipelas cutaneous and pulmonary, there were the same rapidity of effusion of white cells, the same want of plasticity. In short, the anatomical constitution of the pulmonary alveoli, as the labours of Ranvier have made them known to us, is singularly similar to that of the areolar connective tissue, it is not astonishing, therefore, that almost similar

anatomical structures should be the seat of pathological processes almost indentical. For these reasons we believe we may, without temerity, establish the fact of a special, if not specific, pneumcnia, an erysipelatous pneumonia or what was more properly designated by the ancients "erysipelas of the lung." (Read before the Société médicale des Hôpitaux.)—*L'Union Mèdicale.*

CARDIAC HYPERTROPHY AND RENAL DISEASE.

Professor Buhl, of Munich, whose name is familiar to us from his researches on tuberculosis, has published a paper on the connection between renal disease (granular kidney) and cardiac hypertrophy, which, judging from the abstract of it in *Centralblatt f. d. Med. Wiss.*, 1878, page 668, is likely to set the pathological world a-thinking. The original paper is entitled, "Mittheilungen aus dem pathologischen Institut zu München, 1878."

Von Buhl rejects both the theories of Traube and of Gull and Sutton, as to the causation of the hypertrophy of the heart in Bright's disease, and, though it is not so stated, it is clear that, in part at least, Dr. G. Johnson's view, as well as Ewald's, lately referred to in this journal, would also be set aside.

The following points are urged against Traube's theory—(1) The occurrence of eccentric hypertrophy of the left, or of both ventricles without the presence of granular kidney; (2) the occurrence of well-marked granular atrophy of the kidneys without hypertrophy or dilatation of the left ventricle; (3) the occasional existence of left ventricular hypertrophy without dilatation; (4) the complete absence of signs of a dilated arterial system, which would be the necessary consequence of increased arterial tension; (5) the absence of cardiac hypertrophy in other forms of renal atrophy. Von Buhl further points out (6) that Traube's theory does not explain the hypertrophy of the right ventricle, which coexists with that of the left in 70·8 per cent of the cases; and that (7) the hypertrophy of the left ventricle is often present *before* the kidneys are atrophied.

Gull and Sutton's view, that the hypertrophy is due to a general fibrosis of the arterio-capillary system, is met by some of the objections raised above, and also by the facts that at the commencement of the renal affection the fibroid change in the arteries and capillaries is not present, and that it is rare for any other organ except the kidneys to be decidedly shrunken, whereas in a general fibrosis we should expect all highly vascular organs to suffer.

One general objection to all theories of increased arterial tension as a cause of the cardiac hypertrophy, and especially to Traube's theory, is the development of a *collateral circulation* in the kidney itself, by which the place of the constricted vessels is taken by others. According to Von Buhl, on the one hand the vessels of the fat capsule, and the fibrous coat of the kidney, and the capillary network of the cortex, dilate; and on the other, the blood is diverted into the vasa recta, which run in parallel bundles from the boundary line between the cortical and tubular substance into the latter. The lateral pressure in these vessels is much raised, and their diameter becomes doubled or trebled. The resistance of the vasa efferentia becomes of no importance, the blood enters the veins more freely, and the increase of pressure in the dilated vessels is relieved by increased excretion of water. The real connection between renal atrophy and cardiac hypertrophy, according to Von Buhl, is as follows, and it will be at once evident how much his hypothesis differs from the ordinary explanations of these phenomena. He asserts (1) that kidney and heart are simultaneously affected, but that the hypertrophy of the heart is due to myocarditis, the result of inflammation of the pericardium, the valves, and the heart-muscle itself, some form of which is present in 65.7 per cent. of the cases he has examined. The time when this inflammatory process occurs is the commencement of the renal affection. Now, the myocarditis may either leave the heart atrophied at once, or more commonly be followed by dilatation, owing to the diminished resisting power of the diseased muscle to the blood pressure, and afterwards by atrophy.

As a fact not previously noticed, Von Buhl describes *a relative contraction of the aorta* in these cases, which intensifies the hypertrophy of the left ventricle. Hence he explains the

increased arterial pressure and cardiac hypertrophy, not by granular atrophy of the kidneys nor by a general arterio-capillary fibrosis, but by the hypertrophy of the left ventricle and the relative constriction of the aorta.

The other changes in the arterial system are sequelæ of the heart disease. The arterial fibrosis of the kidneys is also secondary. Lastly, it is possible that excessive muscular exertion, and especially that of the cardiac muscles, may lead to myocarditis, eccentric hypertrophy of the heart, and other pathological changes met with in Bright's disease. Thus these conditions may be a not infrequent cause of this form of disease.

This short sketch of Von Buhl's new views necessarily excludes the data on which they rely for support, but his eminence as a pathologist must at any rate enforce their consideration, even though they deal roughly with current ideas.—*Med. Times and Gaz.*

TREATMENT OF CARDIAC DYSPNŒA.

Professor Sée says (*Concours Méd.*, July 12, 1879) that in all cases of continuous cardiac dyspnœa he has found iodide of potassium answer very well, especially where the dyspnœic symptoms were combined with a lesion of the tissue of the heart. It is equally useful in valvular lesions. Even if the diagnostic error of mistaking a simple cardiac dyspnœa for true asthma should be committed, the use of iodide of potassium would not be followed by any evil results, as it is an exceedingly useful drug in asthma. The direct effect of iodine in such cases is the promotion or rather liquefaction of the bronchial secretion. This greatly facilitates respiration. The dose given by M. Sée is 1.25 grammes per day; this is gradually increased to from 2 to 3 grammes, and is made as follows: R. Iodide of potassium, 10 grammes; Syr. cort. aurant, 200 grammes; 2 to 4 tablespoonfuls per day. Each spoonful must be dissolved in a tumbler of water. Patients suffering from heart disease take iodide of potassium very well—better than other patients. The following are the drawbacks of this drug: 1. Bleeding from the buccal mucous membrane, or bronchitis and hæmoptysis in tuberculous patients. (Phthisis is therefore a counter-indication for the use of iodide of potassium.) 2. Loss of flesh: in fat individuals this is to be regarded as a favourable symptom. 3. Loss of strength: in such cases the treatment must be suspended at once. 4. Loss of appetite. Opium may be added to iodine, in order to prevent the evil effects of iodine. R. Iodide of potass., 10 grammes; Syr. cort. aurant, 200 grammes; Extr. thebaic, 0·10 to 015 gramme. From 2 to 4 spoonfuls per day. For the extr. theb. the syr. papaveris may be substituted (50 grammes). Opium is given here with a view of making the iodine more easily tolerated, and of diminishing the cough, which greatly inconveniences the patient. Another very useful combination is that of digitalis with iodine, as the one has a soothing influence on the dyspnœa by acting on the lungs, and the other increases the action of the heart and modifies the arterial tension. The following formula will be found to answer well: R. Julep gommeux, 100 grammes; Iod. of potass., 2 grammes; Tinct. digit., g. 40; or the following formula: Extr. gent., 0·10 gramme; Pulv. fol. dig., 0·15 gramme. To take one pill three times daily, together with the sol. of iodine, which we have mentioned above. In cases where patients cannot take digitalis, chloral will be found to be a good substitute. Thus, *e.g.*, Julep gommeux, 120 grammes; iod. of potass., 2 grammes; chloral-hydrate, 4 grammes. To be taken every two hours during the day. —*London Med. Record.*

A New Hemostatic, prepared by Carlo Pavesi, has achieved quite a reputation, and consists of sulpho-carbolic acid twenty five parts, alcohol twenty-five parts, benzoic acid five parts, tannic acid five parts, glycerin twenty-five parts, and rose water two hundred parts. The sulpho-carbolic acid is prepared by mixing one part sulphuric acid and one half part carbolic acid, and heating for a few minutes on a water-bath. The benzoic acid is dissolved in the alcohol and glycerin, and the tannic acid in the water. The mixture is clear, straw-coloured, has an acid taste, is neither caustic nor irritating, and coagulates albumen, milk and blood. *American Jour. Pharm.*

Surgery.

CLINICAL LECTURE ON MALIGNANT STRICTURE OF THE HEPATIC FLEXURE OF THE COLON.

BY JAMES F. GOODHART, M.D.

Assistant Physician to Guy's Hospital and the Evelina Hospital for Children.

(Concluded.)

In the first two days he was sick, and had severe paroxysms of pain; still there was no visible peristalsis. The next two days he was quite comfortable, without sickness, the bowels acting with normal motions, and only one short paroxysm of pain. He was so comfortable, and complaining of feeling hungry, that I was somewhat thrown off my guard, and consented to his having a little fish. Whether from this increase of diet or not, I cannot say, but on the evening of the day on which fish was taken, he had sudden and severe abdominal pain, which produced speedy collapse; and, notwithstanding a liberal administration of opium, wisely given by Mr. Horrocks, when I saw him the next day he had the sunken eye, the cold skin, the thready pulse, of a patient with acute peritonitis on the point of death. After this, he vomited everything given him, which was very little; for I believe the best treatment in peritonitis is to give no food at all, and plenty of opium; and he died about sixty hours after the onset of his last attack of pain.

The *post mortem* made the same afternoon discovered a cancerous stricture of the hepatic flexure of the colon. This had led to ulceration above it in the ascending colon, and a large fæcal abscess had formed in the right hypochondriac and lumbar region. Suppuration had extended from it to the viscera in the neighbourhood, and so to the general peritoneum. We also found evidence of old peritonitis in the form of old adhesions; and these were associated with, and probably due to, old tabes mesenterica, of caseous and now calcareous disease of the mesenteric glands.

Now, remember my diagnosis was gastric ulcer, opening into the tissues outside the stomach, and so leading to the formation of inflammatory material, which had caught up the colon and impeded its action, but had not constricted its calibre to any great extent. Inflammatory products outside the stomach there were in plenty, but they originated not in the stomach, but in a stricture of much tightness in the colon.

How was it that we failed to diagnose this? Well, because the proper or usual symptoms were absent. The symptoms of stricture of the colon are paroxysmal colic, visible peristalsis, constipation, and distension of the abdomen; and, of these, some are much more significant than others. For instance, the paroxysmal pain is present in most intestinal inflammation and obstruction, whether in small or large intestine. The visible peristalsis may or may not be present; but, at any rate, in a tight stricture of the colon you would expect to find constipation and distension of the abdomen. If these be absent, I hardly know any condition which would enable you to make a diagnosis; and I do not see in this case, now that we have the *post mortem* to guide us, how we could have arrived at a perfectly correct opinion. If there be no distension, you will be justified in assuming that obstruction, if it exist, is very high up in the small intestine; or that it is a general contraction, such as I mentioned to you; or that it is not complete enough to hinder to any material extent the passage of the intestinal contents. I took the latter view in this case.

But the *post mortem* shows, I think, why the important symptoms were absent; and, in so doing, conveys a very important lesson with regard to treatment; indeed, the most important lesson that can be learnt in these cases. Remember that the stricture occurred at the hepatic flexure of the colon, and that above that, ulceration had occurred in the mucous membrane of the bowel, and a communication had thus formed between the intestinal canal and the loose cellular tissue outside in the loin. This had allowed of the escape of a quantity of the contents of the bowel into the large abscess we found, which was without doubt due to the ulceration of the intestine, and some relief to the distension of the bowel above the stricture.

Now, it is a well known fact of *post mortem* experience that strictures of the bowels are *never complete*. There is always a certain

amount of channel left, usually enough to squeeze the index or little finger through. So that it is probable that the fatal obstruction occurs from some temporary condition of the canal, which converts the partial into a complete obstruction. The treatment of these cases quite confirm this. Many are the cases, even of those which eventually have proved themselves due to carcinoma of the bowel, where the temporary condition has been tided over and the complete obstruction relieved. The conditions which cause this appear to be either paralysis of the muscular coat of the bowel; or some alteration in the direction or irregularity in action of the muscular force, by which means the contents fail to be propelled through the narrow canal in front of them; or some alteration in the contracted ring of bowel by which the existing canal becomes temporarily still more narrow. But whether one or all of these conditions hardly matters, because they all result more or less immediately from overdistension above the stricture. So that, in treating these cases, this is what you aim at, the unloading of the bowel above the stricture and keeping it as empty as possible. If you can do this, the symptoms disappear and the patient regains health, which of course will be lasting or not according as the stricture is carcinomatous or not, and according as the overdistension can be obviated in the future.

The most obvious way of accomplishing your object is, to those who have not seen the ill effects of their administration, to give purgatives, the *rationale* of such treatment being, no doubt, apparently to stimulate the muscular coat behind the obstruction and so to force the contents of the bowel through the stricture, but this is what does not happen; purgatives seem to create somewhat analogous conditions in those occurring when a large theatre or church full of people is set on fire and all the occupants attempt to rush out at once. You know what happens. Half are crushed at the doors and the other half burnt inside. Convert that into terms of intestinal obstruction, and the result of purgatives is generally either to produce ulceration of the bowel above the stricture or to make the obstruction more complete than before.

The proper procedure first at hand is to reduce the contents of the intestine above and below the stricture to the smallest possible amount. Above, you are helped in this way by the vomiting which is usually present; and all that it will generally be necessary to do will be to be passive, and put no more in to replace that vomited. Your duty is to starve—yes, literally to starve—the patient. He may suck a little ice, and have a mouthful occasionally of the weakest broth; and this rather to calm his mind than to sustain his strength. We need not mind about that. Most of these patients have a certain reserve in their blood and tissues to fall back upon; and in bed strictly at rest they are in no danger of dying from a day or two of foodlessness. You will clear the intestine below the stricture by copious enemata frequently repeated. Then, as to drugs, the first and by far the most important one is opium. This controls and moderates the intestinal muscular action, and in so doing, without any other means, will often put a stop to the obstruction. So quickly does it accomplish this sometimes, that the opium pill would almost appear to act as a purgative, only that positions are changed now; purgatives constipate, sedatives open the bowel. If the symptoms are severe, give no more than opium and wait; but in the less urgent forms of obstruction, both belladonna and nux vomica are of use.

With regard to belladonna, Dr. Norman Kerr has published some remarkably successful cases of the subsidence of the symptoms of intestinal obstruction under one and two grain doses of the extract, given at frequent intervals. I have lately had a case under my own care where I pursued a similar plan, the patient taking twelve grains of the extract in about thirty-six hours; but, unfortunately, the result was not successful; peritonitis supervened, and death took place as colotomy was being performed. I do not wish to imply that this treatment is valueless. I think now that the case was perhaps of too long standing to allow of any hope of success except by operation; and would suggest that the belladonna should be exhibited in the earlier days of the obstruction if it is to succeed. We certainly lost

valuable time, which might have allowed of successful colotomy, while pursuing the belladonna treatment.

I see no reason why ergot and digitalis should not be of use also; although they are less generally applied to. All such drugs, acting as tonics to the muscular coat of the bowel, induce a more persistent and forcible *vis à tergo*, replacing an irregular and inefficient muscular action. These, with warmth to the abdominal parietes, will be successful if any measures are of avail, and it will not often be necessary to do more by way of drugs. Some advise the administration of oil and other fluids to liquefy the intestinal contents; this is quite unnecessary, and even harmful, by adding to the quantity of liquid above the stricture, for it is a rule, to which I have seen no exception on the *post mortem* table, that *the intestine above the stricture is distended by fluid faces, not by lumpy matter.*

Well, then, should all these measures fail, and you have to do with stricture of the colon, and have only to consider the question of the relief of the stricture apart from its nature and other complications, then the proper thing to do, no doubt, is to open the bowel above the stricture by some surgical operation. Now, in deciding upon such a thing as this, it is perhaps more common to look upon the operation as a way out of a difficulty by avoiding it; as a means to secure a permanent opening above the stricture—an artificial anus in fact. But —and this is the point I wish to insist upon, for here it is that one of the points of our case come out—in many cases you will find that after the colotomy the bowels act and continue to do so by the ordinary channel. You relieve the overdistension by the operation, and the obstruction ceases. So that the operation is remedial in such. You do, in fact, by operation what you have previously attempted by drugs, and do not merely use a makeshift.

A very interesting case of this sort has been published in the *Guy's Hospital Reports* by Mr. Hilton. A medical man suffered for some time from abdominal pain and constipation, and eventually the obstruction became complete. Mr. Hilton saw him after twenty-eight days, and agreeing with the other medical men in attendance that the seat of disease was in the rectum or sigmoid flexure, opened the colon in the left loin. Four days afterwards, evacuations began to pass *per anum*, and from that time this continued to be the case; and the opening in the loin gradually healed. Eleven weeks after the first operation, all the old symptoms returned, and it became necessary to re-open the colon, when again fæces passed naturally *per anum;* and again—though this time vigorous efforts were made to dilate the artificial opening, the incision healed at the end of eleven weeks. The patient went on for some weeks, when it became necessary to open the colon a third time. By this time ulceration had occurred in the colon above the stricture, and a large abscess had formed outside the bowel, opening the hip-joint, and from which he ultimately died exhausted. He lived a year almost to a day from the time he was first taken ill, and eleven months after the first operation.

In our case, you will remember, there was no distension of the bowel, and nothing that could be called constipation, and I attribute their absence to a similar reason to that which existed in the case just narrated; viz.: to the presence of a safety valve above the stricture, the only difference being that in the one case it was made by the surgeon, in the other by the spontaneous morbid process of ulceration; and in our case, instead of being remedial it was a case of "out of the frying-pan into the fire." I can only suppose, however, that the ulceration which we found in the ascending colon had allowed the escape of fæcal matter into the cellular tissue of the right loin, and in this way had in some measure relieved the distension which must otherwise, almost of necessity, have ensued above the stricture, and so the bowel was allowed to act.

You may perhaps think that some less hazardous means of relieving the distension than that of colotomy might be adopted, and another operation has been practised with that end in view, viz., paracentesis. The distension is due partly to gas and partly to fluid fæces; and it has been thought that by withdrawing the former the severity of the case might be relieved. One of the distended coils

has therefore been tapped by a very fine trocar and cannula. But there can be no doubt that this is an exceedingly dangerous thing to do; and I do not, from what I have seen and others have told, feel in the least inclined to recommend it to your notice. The danger is this: that the distension is, in the majority of cases, but little relieved—that alone is an objection fatal to its adoption—and the bowel remaining full and its walls tightly stretched, fæcal matter, which you remember I told you is always liquid, leaks out into the peritoneum after the withdrawal of the cannula from even the smallest puncture. I have myself seen this operation performed, and fæcal matter came out at once by the cannula, no relief followed, and the patient died not long afterwards of acute peritonitis. So do anything rather than this. You are taught, and quite correctly so, that small wounds of the intestine are comparatively dangerless, because the mucous membrane becomes everted and so closes the aperture; but this only applies to a contracted intestine; we are dealing with an overfull one. All the coats are in such a case distended probably to their utmost, the rugæ obliterated, and there is nothing to evert; and the smallest hole, under such circumstances, becomes a vent, and a vent, however small, in such a position, is fatal. Of course, all these points are beside the question in our case, because there was no distension of the abdomen and no constipation, so that we had nothing to consider but the treatment by drugs.

One other fact in our case must be alluded to, if for no other reason, because you will not find much about it in your books. We found evidence of old peritonitis, and the glands in the mesentery were caseous or calcareous, and there had evidently been a so-called tabes mesenterica of former date, from which the patient had recovered. That condition is of sufficient interest in itself to devote a lecture to; but the point in this case is, that such a state of things must of necessity somewhat modify the distension which we should expect as the result of obstruction, and might in some cases prevent it entirely. It may, in conjunction with the other previously mentioned conditions, have so acted here. It is quite obvious that if the intestinal coils are matted together and to the surrounding parts, and the mesentery itself be shortened and thickened, there is less chance at any rate of the usual uniform distension, and it may be, as I say, that none will be present.—*British Medical Journal.*

EXPECTANT TREATMENT OF SYPHILIS.

Zeissl states that he writes this series of articles in response to a number of questions which have been addressed to him, verbally as well as through the press, asking why he has so materially altered his views concerning the therapeutics of syphilis of late years, and what his present ideas upon the subject are.

He speaks of having grown up in medicine with Hebra, Skoda, Rokitansky, Dietel, and witnessed their struggles against hypermedication in diseases, notably Dietel's successful treatment of pneumonia, typhus, etc., by pure expectation.

This determined Zeissl to try expectation in the treatment of syphilis when he had a good opportunity. Up to 1864, when he published his "Lehrbuch," this opportunity had not arrived, therefore in this book he adhered to the classical methods with which he had long been familiar, mainly in the hands of others.

In 1869, in the K. K. Allg. Krankenhaus, a second division and clinique for syphilis was established and given to Zeissl, thus furnishing him an in-and-out-service with twelve hundred and fifty subjects, of which four hundred and fifty to five hundred were syphilitic.

Here was the long-wished-for opportunity, and Zeissl immediately commenced to improve it. He selected from his patients who had the initial lesion of syphilis a number having as nearly as possible similiar constitutions, put them on regular diet, treated the chancre with lime-water, carbolic acid solutions, and the like, and waited for secondary symptoms.

When general symptoms appeared the patients were divided into three classes. One lot got mercurial frictions, another preparations of iodine, the third purely indifferent preparations, to satisfy their minds that something was being done.

He now observed that in many cases ten to fourteen frictions promptly dissipated the symptoms, while in other cases the symptoms remained considerably longer, in spite of the frictions. He noticed that the internal use of the preparations of iodine was followed by a disappearance of the symptoms often within two weeks, but that many cases required four

to eight weeks, and others a longer time for involution.

In the cases treated by expectation he found that the secondary outbreak disappeared in from four weeks to several months, while in two cases a syphilitic exanthem disappeared entirely in fourteen days without any treatment.

In this way Zeissl learned that syphilis was atypical, seeming to depend for its course largely upon the physical individuality of the patient, the symptoms being short or long in duration, light or severe in type in different cases, irrespective of treatment. He noticed that gummatous forms of syphilis appeared as well in the cases treated by expectation as by other methods, but, he thinks, much less often of iodine. He noticed, also, that after a mercurial treatment relapses were more frequent and, as a rule, more obstinate than after treatment by expectation or by the preparations of iodine. He noticed that when treatment by iodine or expectation did not cause the early symptoms to disappear in four weeks, inunctions (ten to twelve) with mercurial ointment caused the symptoms to cease.

Zeissl states that if the first eruption be allowed to disappear without the aid of medicines and no other symptoms come on for one year, the patient may be considered to be well.

This expectative treatment requires patience, all the eruptions requiring considerable time to disappear, but Zeissl considers that by this treatment, with appropriate diet, cure is possible.

Zeissl here parenthetically remarks that he is not an anti-mercurialist; on the contrary, he thinks that the preparations of mercury are of great value, and in many cases of syphilis indispensable. He shelters his conclusions behind the clinical observation of forty thousand syphilitic patients encountered during an observation lasting over many years.

Of one hundred patients treated for the first eruption with mercury, Zeissl says that ninety-six will have relapses. He thinks that the early syphilitic headache disappears most promptly under three or four frictions of mercurial ointment, ʒss each. He believes that early syphilitic symptoms disappear most quickly, as a rule, under subcutaneous injections of calomel, but condemns the method on account of the painful inflammatory exudations which occur at the points of puncture.

Zeissl's ground is that mercury is not a bad agent, but that its early use is bad. He believes that syphilis should have a given time to blossom and ripen as it were, two or three months, and that then the mercury should be used in great moderation,—ten to twelve frictions or injections. He does not use mercury at all until the expectant methods and that by the preparations of iodine have failed to give satisfaction; and he believes that in this way he obtains the greatest good for his patients, the quickest as well as the most lasting cures.

When no treatment is used the eruptions cease to appear on an average in from two to eight months. Defluvium capillorum and glandular engorgment last often a year. Relapses, especially of a severe character, have been observed very seldom by Zeissl after an expectative treatment.

Although Zeissl believes the expectative method the best, still he rarely practises it; in hospitals, because the patients must get cured of their symptoms and go to work again; in private, because patients are unwilling to let their symptoms work themselves out but demand a quick relief.

Consequently the method followed in the clinique is iodoform or indifferent local applications to the chancre. When the first eruption appears,

℞.—Tinct. iodinii, 2.00;
Aquæ dest., 200.00.

If this causes cardialgia, he gives

℞.—Potass. iodid., 10.00,
vel natrii iodid., 10.00,
Pulv. et extr. gentianæ, āā q. s.,
ut fiant pil. No. 100.
8–12 morning and evening.

Iron is given (iodide of iron) to anæmic patients in solution in a dark syrup to prevent decomposition by the light, or in pill form.

If the syphilitic exanthem resists this treatment for six weeks, then he employs mercurials in injection, friction, or internally, being very careful that the patient keeps the skin and mouth in good order.

Much detail follows about the use of frictions and injections, and their results. The only preparation he uses by the stomach is the following:

℞.—Calomelanos, 0,15;
Extr. belladonnæ, 0,07;
Sacchar. alb., 3.00.
Div. in dosis æqu. No. 8.

One powder to be taken four times a day.

Mercurial fumigation and mercurial suppositories he has not used at all for many years.

Zeissl has employed tayuya in fifty cases, but has not made up his mind about it except that he has decided that it can do no harm in health or disease. The appetite improves under it.

Diday is quoted in support of the author's views.

In brief, it seems that Diday and Zeissl think alike, and Sigmund seems to join them, that chancre and the light early eruptions should be treated by expectation without specifics. Next, that harder cases require preparations of iodine, and finally, only severe ones and those not yielding after a fair trial of the other methods demand mercury.

In short, nearly all the world at the present day seems to be coming to a belief that mercury is very powerful and must be sparingly used, either for only a short time in reasonably large quantity in hard cases, or for a long time in minute doses, either continuously or intermittently as others believe—*Wiener Med. Wochens.*, 1879, Nos. 1, 2, 3, 4.—*Arch. of Dermatology.*

A Contribution to the Treatment of Psoriasis.—Preismann calls attention to the urgent necessity for removing the scales before applying a remedy to the diseased spots, and speaks of the difficulty of doing this thoroughly. For this purpose he was led to use, and now highly recommends, a solution of salicylic acid in alcohol, one part to sixteen. When this solution is rubbed lightly upon a patch with a cotton swab the scales instantly become loose and fall off, leaving the patch red, dry, and even. It also removes the grease and renders the action of the subsequently applied medicine much more efficacious. The lotion acts very efficiently in relieving the itching, and he has found it useful in chloasma, lentigo, etc.—*Wien. Med. Presse*, 1879, 16, s. 514.—*Archives of Dermatology.*

CLINICAL CONVERSATIONS ON DISEASES OF THE SKIN.

BY L. D. BULKLEY, M.D.

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Case II. Acute Papular Eczema.—Eczema is so constantly associated in the minds of the profession with vesicles that few of you would at first be prepared to call the eruption before you by this name. But if it be borne in mind that eczema is essentially a polymorphous eruption, capable of assuming the characters of very many other diseases, that it may appear and run its course as an erythema, or as a papule, or, as in the palms, that there may be simply thickening of the fissures, etc., you will be better prepared to make a correct diagnosis.

This man, Frank B., a bricklayer, aged 22, first noticed a papular eruption appearing on the arms and abdomen five weeks ago, which lesion has continued to develop and increase until the present time. You now see a considerable portion of the trunk and extremities covered with an eruption of small papules, intensely congestive, inasmuch as they disappear largely on pressure; you will notice that the flexor are affected much more severly than the extensor surfaces: the papules, which are quite thickly set, are in places gathered together in patches, and on some of them you may already observe a desquamation. There is great itching and burning over the whole surface.

He tells us that he has been taking sulphur internally and using a sulphur ointment to the eruption, which latter well accounts for the acutely inflamed condition of things. You know that sulphur is thought to be "good for skin diseases," and you would really be surprised to see how continually it is advised by patients, druggists, and even physicians, in the most varying eruptions. Now, while in chronic conditions of the skin it oftimes does serve as a good stimulant, in the acutely inflammatory condition or in a newly-developing eruption it is worse than useless, it is positively harmful; the only exception to this being in the case of scabies or "the itch," where it has a parasiticidal action, and even here it may occasionally create a very consider-

able artificial inflammation and hinder the progress of the case.

Let this case, then, be a warning to you against employing sulphur unnecessarily, for we may safely say that a large share of this irritated, distressing condition of the skin is due to the remedies he has employed.

We will order him a laxative composed of blue mass, compound colocynth extract, and ipecac, and give him tolerably full doses of acetate of potassa, to relieve the cutaneous congestion, and with a little weak zinc ointment (gr. xxx ad ℥i) we will find the eruption will fade rapidly. Later, I would give him locally the oil of cade mixed with cod-liver oil (℥i ad ℥i), which is an excellent application where a large surface is involved, but it would be much too stimulating at the present time.

Case III. Lupus Erythematosus. — This woman, aged 27, presents a lesion the true nature of which was long a doubtful question among dermatologists, and, indeed, there is yet very much to learn in respect to it. Bearing in mind the older descriptions of what was called lupus, remembering perchance some case where great destruction of tissue and disfiguration of the patient had resulted from lupus, one would hardly be prepared to give the same name, even when modified by *erythematous*, to such a picture as is presented by this patient.

Both cheeks and the nose are seen to be the seat of a reddened integument, presenting sharply-defined borders, and almost perfectly symmetrically developed. It requires no great stretch of imagination to liken the appearance to a butterfly, the body being represented by the nose, while the two patches on the cheeks answer to the wings,—a comparison frequently made by Hebra.

On close examination certain portions of this eruption are seen to present a very curious appearance, which is peculiar to this disease. This is a certain blocked-up condition of the sebaceous follicles, which are each seen to be filled with a horny plug; and where this has been removed artificially, as by treatment, you see the mouths of the follicles gaping, and evidently surrounded by infiltration. I have likened them in this state to a wax preparation into which numerous pin-holes had been made, so unyielding does the surface appear. When such cases are not treated locally a certain amount of crusting will form on the surface, and on removing this its under surface will be seen to be covered with minute prolongations, which represent sebaceous plugs which have have been drawn from the dilated follicles.

So striking is this sebaceous feature in certain cases, that Hebra originally described the disease as seborrhœa congestiva, and it is only comparatively recently that microscopic study of sections of skin taken from these cases has established it as a variety of lupus.

But although a variety of lupus you need not look for any of the destructive results which are associated with that name; this eruption generally leaves a superficial cicatrix, which is often very slight indeed, but sometimes quite disfiguring, though it never reaches beneath the tissues of the skin itself. You will notice that this surface is very even and uniform, it has none of the separated and isolated pulpy tubercles which characterizes the ordinary lupus, lupus vulgaris, which you know is sometimes seen in a very superficial form; nor has this any of the flat epithelial scales, attached quite firmly on ones ide, which you see in lupus vulgaris.

To those not specially acquainted with skin diseases syphilis always occurs to the mind at once as a cause; suffice it to say syphilis never presents any lesion which could resemble the case before you, even in the slightest degree. There are few, if any, sensations in this eruption; she says it does not itch, but burns a little occasionally; this alone would exclude eczema, which in this locality especially is distressingly itchy. Besides, this has never been moist at all, nor scaly, nor fissured; and on pinching up the surface you get very little thickening, a prominent characteristic of eczema on the face. I cannot think of any other eruptions with which you should confound it.

Unfortunately, the treatment in this, as in most cases of this disease, has not yielded any very good results as yet. The eruption is essentially a chronic one, and often resists treatment amazingly; in this case the eruption has certainly spread under various measures which have been employed, although now it seems to be at a standstill.

Internal remedies have little, if any, effect in checking the disease, although sometimes improvement will seem to follow them. This woman is now taking the eau de bourboule, the French natural arsenical mineral water, and there has been some improvement since it was employed, but I would by no means yet recommend its use until further investigations have been made.

Locally she has used the compound tincture of green soap followed by zinc ointment, and at first I thought there was some improvement under it, but afterwards the eruption spread greatly under its use. She now finds that the sulphuret of potassium and zinc lotion (℞.—Potass. sulphuret., zinc sulphate., āā ʒi; aquæ rosæ, ʒiv), which I prescribe so frequently in acne, cools the face greatly, and under it the eruption certainly appears much less pronounced; but lupus erythematosus is a disease about which a hasty judgment can never be formed.—*Archives of Dermatology.*

Contribution to the Study of the Local Treatment of Psoriasis.—Besnier states that the treatment of psoriasis by arsenic does not prevent relapses. Until within a few years the best local treatment was the use of oil of cade; but chrysophanic acid has proven itself a better remedy, the principal objection to which is the staining that it produces. Pyrogallic acid, in his experience, is not inferior to any other local remedy, and appears to have certain peculiar advantages. It has no bad effects, and its action, though slow is effective, and it produces but little irritation. The brown colour which it leaves disappears in a few days, and it has no unpleasant odour. He uses it in the form of a salve, in the strength of five to twenty-five per cent., rubbing it on, after removing the epidermis by soap, every two or three days. This treatment was always followed by relief, which was usually permanent. — *La France Méd.* March 12, 1879, p. 161.—*Archives of Dermatology.*

Dr. Seth W. Williams, senior assistant in Bellevue Hospital, recently died of the very rare disease, idiopathic cerebral abscess.

Original Communications.

SMALL-POX IN ONTARIO.

FROM OCTOBER 1878 TO DATE.

BY A. A. RIDDEL, M.D.

Read before the Toronto Medical Society, Nov. 20th, 1879.

It will be remembered by those who may have perused the first part of the paper on the above subject, read before this Society on the 26th June last, that it was therein stated that I had written to medical men, and, where I could not ascertain whether any member of the profession resided, to lay friends, in those places where I had heard or seen it stated that small-pox had existed, for information. At that time some of those written to had already furnished the necessary particulars, and since that date others have responded; but still there are some who have not answered my appeal. To those gentlemen who have supplied what particulars they could, it is almost unnecessary to say that I feel truly grateful; while to those who have not, I have only to remark that their not having done so is to be regretted.

Before, however, referring to the cases in other localities, those that have presented in this city since June will be noted. As but few of them presented any new features, they will be mostly passed over in a cursorily manner. Those presenting anything of a special character will be reserved for a future occasion, when I trust to have the honour of bringing to the notice of the society the histories of some of the singular cases that have come under observation. The numbering of the cases is continued from those already given.

43. On the 6th July I was called to attend a boy, three or four years of age, who had arrived from Ottawa a few hours previously, with uncomplicated confluent. Not vaccinated.

44. On 29th of same month, I saw a young man on Queen-street west, in second day of confluent. He was removed to the hospital early next morning. His was a unique case. The day before he was seen by me Dr. W. W. Ogden had visited him, and found him with fever and some of the other symptoms of small-pox, but there was this singular feature present —the wrists, elbows, knees, and ankles, were of a deep red erysipelatous blush. The face was slightly red; but it was not till the morning of the day I first saw him that any papillæ presented. In the evening of that day his face was thickly studded with them, and they were scattered over the greater portion of his body. He had been vaccinated some six years before, and had a large, fair-looking cicatrix on the right arm. Nevertheless he had a severe form of confluent, with

malignant symptoms prominent. The cuticle around the joints first attacked became, as it were, gangrenous; and the fingers and toes partook of this character to such an extent, that it was feared he would lose them. The entire skin of the hands and feet formed those ill-looking, dark sanious bullæ, often seen in this disease, and unhealthy ulcers presented about the joints first attacked. He is of a frail, scrofulous constitution.

45. 30th July. A girl, 7½ years, was admitted from Edward Street. She was in fifth day of confluent, which took the usual course, except that the pustules dried very slowly, having first assumed the flattened form and ash-like colour so indicative of danger. There were the usual restlessness, insomnolence, jactitation and delirium, seen in severe confluent cases. She recovered. Vaccinated five years previously, but the cicatrices were scarcely visible.

46. 11th August. A little girl, aged three years, was admitted from Teraulay Street, in fourth day of confluent. She appeared to be doing well till the night of the 14th, when the pulse became small, weak, and flickering, and could not be counted because of its feebleness. She died next afternoon. Not vaccinated.

47. Same day. A sister of above, convalescing from varioloid. Vaccinated.

48. 12th. A brother of No. 45, aged four years, in first day of confluent. Vaccinated four days before admission. He had non-complicated confluent.

49. 13th. A young man, brother of Nos. 46 and 47, from Teraulay Street, with a mild form of varioloid. Vaccinated.

50. 16th. A man from Elizabeth Street, in second day of diffuse varioloid. Vaccinated when young, and had three large superficial cicatrices on right arm.

51. 18th. A boy, aged 12, from Don Mount, township of York, in fourth day of confluent. This was one of the worst cases that I have known to recover. Non-vaccinated. The condition of this boy was such that the fetor from his almost putrid body soon rendered the air of the room in which he was placed exceedingly offensive, notwithstanding the doors and windows were always open. Consequently, in the attempt to save his life, he was removed from one apartment to another whenever the air in that in which he lay was found to be tainted, —the few patients in hospital fortunately permitting his removal to four different and thoroughly clean rooms, as occasion required.

52. 24th. A young man, brother of Nos. 46, 47 and 49, in second day of varioloid. The following day petechiæ of a mahogany colour showed themselves on the lower part of the abdomen and thighs, denoting somewhat of a malignant type. These gradually subsided. Vaccinated. Had two cicatrices on left arm, the upper being of good appe
lower only superficial.

53. Same day. A young man, brother of No. 45, in second day of varioloid. Vaccinated when young.

54. 27th. A woman, wife of No. 50, in second day of what proved to be severe confluent. Two days after admission she was attacked by metrorrhagia, the discharged fluid being dark, offensive, and non-coagulable. The discharge was much more profuse than usual, dark and offensive. The fifth day after admission there was a slight discharge of blood from the lower bowel. Diarrhœa subsequently set in on two occasions, but was easily subdued. She also had an attack of bronchitis, which proved somewhat troublesome. She was vaccinated when young, but no cicatrix could be found, owing probably to the eruption.

55. 30th. A male infant, 2½ years, son of last mentioned patient, in first day of eruption. Pulse 150, and very small, with fever, laboured respiration, and diarrhœa of a most offensive character. Next day papillæ covered the entire body. It was non-successfully vaccinated ten days before admission, and again vaccinated two days before taken to the hospital. On 1st Sept. there were large vesicles on the latter vaccinated spots. Passive pulmonary congestion was doubtless slowly progressing from the first. The symptoms gradually became aggravated. There were difficult, catching respiration, jactitation, insomnolence, and he died on the 3rd September. In this case the eruption can scarcely be said to have reached the vesicular form.

56. Sept. 2nd. A young man from Ontario Street, in third day of diffuse varioloid. He was in the employ of the undertaker who inters those dying at the small-pox hospital, and buried a child from that institution on the 16th August, the eruption appearing fourteen days subsequent to the exposure. Vaccinated.

57—62. 20th Sept. I was called to see three patients—the father, a son of about 4 or 5 years, and a daughter aged 7, in Dorset Street. The father had the usual initiatory symptoms of small-pox, and a mild form of varioloid developed. The boy was recovering from semi-confluent. Not vaccinated. The girl had high fever; pulse, 150; violent jactitation, suffused eyes, wandering delirium, red face, hands and fore-arms, but no papillary eruption. Chronic convulsions set in later in the day, when a warm bath was given. The mother, necessarily feeling very anxious about her child, sent for me again in the evening. To her urgent inquiries as to the probable fate of her daughter, all that could be replied was:

"Your child cannot survive unless the eruption soon makes its appearance." "But," asked she, "when will it appear?" "It should to-morrow; and then these alarming symptoms may mitigate." Next morning papillæ were scattered over the face and limbs, the fearful symptoms abated, and she passed safely through the discreet form. Not vaccinated.

In my efforts to ascertain the history of these cases, the mother informed me that her brother, a telegraph operator, had had chicken-pox upwards of a month before, and had stayed at her house during his illness; that subsequently both her infant and herself had taken the same disease; and when the little boy took ill she thought he also had it. As he was worse than any of the others had been, she called in Dr. Thorburn, who informed her what the boy was suffering from. Dr. T. kindly turned the cases over to me. She now knew the nature of her own sickness and that of her brother, saying that some of the pustules on her own face were just like those on her children. She was vaccinated. One of her husband's brothers, who had visited the family, had also passed through a mild form of varioloid.

63. 25th Sept. Was called to attend another brother of her husband, on Mutual Street, with a severe form of varioloid. Vaccinated.

64. 6th Oct. Was summoned to visit a woman on Dorset Street, who had humanely assisted the mother of the little girl to give her a bath the day she had the convulsions, with a mild form of varioloid.

The origin of none of the thirteen cases in hospital and nine in private practice, otherwise than as already stated, could be ascertained.

The information that could be obtained from other localities is now given.

Mill Point.—Dr. J. Newton, of this village, very kindly furnishes pretty full details respecting the outbreak and progress of the disease in that locality; but, owing to the nature of this paper, I am obliged to curtail them. The first case was that of a boy who had been attending school at Ottawa. The family with which he boarded were attacked with variola, and his father took him home. The disease manifested itself in him on the 10th June, and in a brother on the 22nd. On 4th August an old lady residing in the township of Richmond, some two miles distant, exhibited the usual symptoms. She had confluent, and died on the 18th of same month. Since the last date up to the 23rd Sept., there had been four cases of varioloid, and four of the discreet form, all of whom recovered. There were also six cases of confluent, with four deaths. Altogether there were seventeen cases, with five deaths. The four varioloid patients had been vaccinated, but none of the others had.

Moravian Indian Settlement.—From Dr. Tye, Thamesville, the following particulars were obtained, his letter being of the 12th July. He had charge of the small-pox patients at the outbreak of the disease, but subsequently resigned, as he found that it injured his private practice. I have since written to Dr. Oronhytekha, who it was said had subsequently attended, but no reply has yet reached me. Therefore, what is here given has been furnished by Dr. Tye. The first case presented on the 12th May, in an Indian girl, aged 13. She was seized with vomiting, bleeding from the gums, and bloody stools. Purpura hæmorrhagica appeared. She died in 48 hours from the onset of the attack. This, from after circumstances, was doubtless a case of malignant small-pox. Three younger children, (of same family, I conclude) subsequently had small-pox, one of them dying. A squaw of 19, six months married, and three pregnant, was next seized. She aborted and died. Her husband became ill within a couple of weeks, and died; and her stepfather, who had visited her during her illness, was likewise seized, but recovered. A woman, aged 29, in the eighth month of pregnancy took ill, miscarried, and died. A squaw, aged 50, vaccinated, had varioloid. A man, aged 40, had confluent, and died the sixteenth day after appearance of disease. The *contagium* was introduced by a sub-chief, who had visited Ottawa. He had a slight attack after his return; but, as he was not very ill, no medical man saw him, and it was not known that he had had small-pox till subsequent events showed the nature of the trouble. His wife, who was six months pregnant, contracted the complaint, but of a favourable type, and did not miscarry. In all there were 42 cases among these Indians, with 16 deaths.

Sandwich.—Dr. Carney, of Windsor, supplies the following respecting the recent outbreak at Sandwich. The disease was thought to have been introduced by a family from Montreal on their way to Manitoba, to whom the railroad lines had refused passage, and who remained over at that town. Up to the date of the doctor's letter, 20th June, there had been 13 cases with five deaths, two adults and three children. The patients that were recovering had all been vaccinated, but none of those who had died had been.

Dr. Sinclair states that there was not a single case in or near the village of Melbourne, a locality in which the papers stated the disease was wide-spread.

St. Mary's.—Dr. Mathieson informed me, on the 21st June, that on the 7th June a man was taken ill of the disease, and died on the eighth day after. He had slept with a man in London, on the 24th of May, in whom the

eruption was just appearing, and who subsequently died. In the particulars given below from a letter dated 7th of July, of Mr. Whelihan, the county registrar, it will be noticed that there is some discrepancy between the statement above given and that made by him. This can easily be explained by the fact mentioned in that portion of my paper read before this society on the 26th of June: that it is exceedingly difficult in cases of small-pox to obtain reliable information. Mr. W. says, that on the Queen's birth-day a man, said to be from London, with small-pox upon him, appeared on the race-course in charge of a horse: that shortly after the ostler at the hotel where this man had stopped took ill of the disease: that the book-keeper and one of the landlord's children were attacked and died: that the hotel-keeper himself and four or five others in the same house were at that time ill with the disease, the place being quarantined; and that there were four cases in different parts of the surrounding country traceable to those in the hotel.

USBORNE.—The following paragraph appeared in the *Globe* of the 5th August: "The small-pox cases in Usborne are at an end. Both Mrs. Smellie and daughter are dead, and the building burned." This township adjoins that in which St. Mary's is situated on the west; and Mr. Clark, township clerk, states that these were the only cases. The girl was servant in the hotel in St. Mary's in which the disease prevailed, took it, went home, and infected her mother.

OTTAWA.—Early in June I wrote to Dr. Lynn, health officer of this city, for information, the disease being epidemic there then. Not receiving any reply from him, I addressed a note to Dr. Leggo, after a lapse of more than a couple of weeks. He kindly favoured me with the following particulars on the 22nd of June: Number of cases in the Protestant hospital since the 1st of January, 24; with five deaths. None of those who died had been vaccinated. There were then 18 cases in the Roman Catholic and 12 in the Protestant hospital. There were several cases in private houses also. He thought, from all he could learn, that there had been about 80 deaths.

As the information supplied by Dr. L. was not as full as could be desired, I wrote a second and third time to Dr. Lynn, but without obtaining any response. On the 9th of August he called upon me, being on a visit to this city, and promised to give me the desired particulars in a couple of days. I accidentally met him on the street about a week after, when he said that he was about to return to Ottawa, and would mail me what was required immediately after his return home. Not hearing from him I again addressed him after a fortnight or so had transpired; and received a note from him, dated the 8th of September, some days subsequently, in which the following is given: Number of cases in hospital from the 1st of January to date, 151; outside, 135. "The rate of mortality of unvaccinated was one out of three. No deaths occurred in those showing good signs of vaccination."

This information is exceedingly meagre and unsatisfactory. It is to be regretted that nothing more reliable could be furnished; and, as Dr. L. informed me that he kept no records, what is supplied is by no means as valuable as could have been wished. It is a pity that in the Metropolitan City of our Dominion a better system of registration during such epidemics as Ottawa has so recently been subjected to, has not been adopted. With two large hospitals, and such a number of cases, there is a wide field for the observation of the most loathsome disease of our climate, in all its varied phases; and it is a sad reflection upon its authorities that no provision is made for rendering that field more fruitful in results that might prove beneficial in the prevention, checking, and curing of the malady. At this date the disease is still prevalent.

LONDON.—Dr. Burgess, of the London Asylum, has very considerately collected the following, with relation to the disease, in and around that city:—A market-gardener, living about two miles out of town, returned on 7th October from Europe (in the same steamer as the cases 1, 4, 11 and 19, of the paper read on 26th June). A few days after his return he became unwell, and presently a slight eruption, which was thought to be chicken-pox, appeared on the face. He was not very ill, and had been vaccinated. This was, judging from what subsequently transpired, a case of simple varioloid. Twenty-seven days after his return his mother was taken ill, when it was found that she had small-pox. Then his father and two sisters were seized, the father dying. Twelve others in the city and neighbourhood were infected. In all there were 11 males, five females, and one infant, sex unknown, 17. Four of the males and one female went to the hospital. The infant, the above-mentioned female, and three males, died.

WHITBY.—From Dr. Eastwood I learn that there was but one case in this town during the winter, that of a man living in the town-hall. There had been a few cases in Oshawa, just previous to his taking ill, but he had not been out of Whitby. A room in the hall was set apart for tramps, and some of those who had lodged there may have had infected articles about them and he been smitten by them. The more probable theory is, that he was indebted

to some of those of his Oshawa neighbours who had either had the complaint themselves or been in bad company, for his misfortune.

OSHAWA.—Dr. Martin and Dr. Rae state that were four cases last fall, none of which were fatal, but two were confluent.

HAMILTON.—Dr. J. A. Mullin states there has not been a case in two years.

MONCK ROAD, TP. OF DIGBY.—First case on 25th October, 1878, in the person of a recently arrived immigrant, by same steamer as Nos. 1, 4, 11 and 19. There were four cases in all with two deaths.

EMBRO.—On 19th October, an immigrant by same steamer so often spoken of was attacked in this village, and died. From this focus the disease spread rapidly about the vicinity till thirty-four persons in the township of West Zorra were taken ill. Four of these were under 12, five between 12 and 23, three over 50, and the remainder were middle-aged. Eight were not vaccinated, and two had the disease for the second time. One pregnant woman took semi-confluent, miscarried, but recovered. Eleven died, one of whom was *said* to have been well vaccinated. For these particulars I am indebted to Dr. Adams.

BARRIE.—Dr. Crookshank states the disease did not make its appearance.

BRANTFORD.—Dr. D. L. Philip gives the following particulars relating to the outbreak of small-pox in this town, in the fall of '78. In September a merchant boarding at an hotel, who had recently been to Toronto on business, took ill with that malady, and supposed that he had contracted it in this city. This supposition could hardly have been well-founded, as there had not been a known case in Toronto for many months. A few cases occurred in Brantford in each of the months of October, November, and December. In January and February of this year nothing of the disease was seen, but it re-appeared in March and April. There were in all about 25 cases, ten being confluent; the confluent form attacking those only who had not been vaccinated. Seven patients died, none of them being known to have been vaccinated.

COOKSVILLE.—The medical man who had charge of the small-pox patients in this village and vicinity, did not reply to the letter addressed him; but from private sources it was ascertained that in early spring there were 17 cases, with three deaths. The disease was supposed to have been introduced by a tramp.

MARMORA.—Dr. Sprague, of Stirling, kindly took the trouble to obtain for me the following facts repecting the outbreak of small-pox in the village and township of Marmora and the township of Rawdon. The first attacked was a baker, in the month of February. As he had not been out of the village for a month, and it was not known that he had been in contact with any one from an infected district, it could not be learnt how he had contracted the disease. But, as small-pox is never of spontaneous origin, he must have been exposed in some way to the contagion. From this man the disease spread, and in February and March there were 22 cases, with six deaths, in the village; 7, with one death, in the township; and 13, with one death, in the adjoining township of Rawdon.

After the publication in the JOURNAL OF MEDICAL SCIENCE of the first portion of the paper on "Small-pox in Ontario," read before this Society on the 26th June last, I received a note from Dr. Rowand, inspecting physician at Quebec, asking the name of the steamer that I had stated had brought the small-pox to that port. Of course, I immediately furnished the required information. In a subsequent note, Dr. R. thanked me for so promptly replying, and gave the following interesting information: Miss Rye brought out a number of children in the vessel. Her servant had been exposed to the contagion of small-pox a few days before sailing, and the eruption appeared during the voyage. She was then isolated, and a very pretty girl detailed to nurse her. The sailors, attracted by the nurse's beauty, assisted her, and carried on a little flirtation. The disease subsequently attacked some of the sailors; and a female passenger being ill with it on the vessel's arrival at Quebec, was sent to the Marine Hospital, where she died. All the other passengers were examined; and none of them complaining or appearing to be ill, they were passed, and went westward. The doctor performed his duty, in accordance with the law; but could not detain the steamer, as vessels carrying the mail are exempt from quarantine. This explanation is due to Dr. Rowand, and is cheerfully given.

From what has been laid before the Society, it will be seen that there have been, according to the returns, the following number of cases and deaths in the localities named, since October, 1878:—

	CASES.	DEATHS.
*Ottawa	266	80
Toronto	61	12
Moravian Indians	42	16
Marmora and Rawdon	42	8
Embro and vicinity	35	12
Brantford	25	7

* OTTAWA.—Dr. Lynn's statement of the total number of cases is most probably far below the mark. Dr. Leggo's calculation respecting the number of deaths is only a supposition, based upon the meagre information he could obtain. The disease is still prevalent in that city.

	Cases.	Deaths.
London	17	5
Cooksville	17	3
Mill Point	17	5
Sandwich	13	5
St. Mary's	13	2
Weston	4	2
Monck Road	4	2
Oshawa	4	0
Don Mount	3	0
Yorkville	2	0
Usborne	2	2
Whitby, Flesherton and Brampton, one each	3	0
Total	570	161

Thus the death-rate was nearly 28½%.

Some of my correspondents have complained of the persecution they have had to undergo, and the pecuniary loss sustained by them, because of their having attended persons ill of small-pox. I can truly sympathise with them, feeling that I have had more reason to complain in these particulars than all my professional brethren put together. If some of those gentlemen were to come to this hypergodly city, with its hundred churches, and professionally attend their unfortunate fellow-creatures who might be attacked with that horrible disease, and that fact to become known, they would soon learn to their cost that it seemed to be not only one of the commonest virtues to annoy, malign and belie them; but the most exalted of Christian duties to anathematise and persecute those whom Providence had seen fit to afflict with sickness.

Of the treatment of small-pox, but little more than what was given in the former paper need be said. Of preventive agents, vaccination stands pre-eminent. Cleanliness and non-exposure may, in a sense, be likewise said to be preventives. Of specific remedies there are none. Sulphurous acid, sulpho-carbolate of sodium, chlorate of potash, cream of tartar, sulphur, and many other drugs, have had their advocates; and I was once strongly urged by a medical brother to send $5 to some nuns somewhere in the States for a bundle of herbs vaunted by them as, and believed by him to be, a positive specific. Not having as much faith as my confrere in Colonel Lane's specific for small-pox, sold by the pious sisters of ——, I did not invest in that nun-such remedy, and can scarcely think that either my patients or myself have been much the losers. The old treatment of low diet, bleeding, antiphlogistics, and close, suffocating rooms, in this disease, is entirely superseded by a more humane and rational system. Pure air; cleanliness; such nourishing food as the patients can take, an abundance of good milk; warm baths; watching the more dangerous symptoms, and combatting them with suitable medicines; warm, well-ventilated rooms in winter, and cool ones in summer, with bedclothes adapted to the season; plenty of fresh, cold water for drinking; enemas in constipation, where purgatives are not likely to be well borne; the eyes protected from glaring light; and whatever drugs are given rendered even to the poorest as palatable as possible, is the best that can be done. Any practitioner pursuing the course here indicated, addressing kind and encouraging words to his patients, and letting them see that he "has a heart that can feel for another," will not have fallen far short of performing his duty.

EXTENSIVE WOUND OF ABDOMINAL PARIETES AND INTESTINE.—RECOVERY.

BY A. C. SLOANE, M.D., ANNAN.

(We must apologise to Dr. Sloane for having made an abstract of his interesting communication, but the exigencies of space required us to do so.)

Mr. H. C., aged 54, and his son were out chopping; the son's axehead being loose flew off striking Mr. C. in the abdomen. Dr. Sloane being some miles distant did not see the patient for an hour and a-half after the accident. He then found him lying where he fell, the body covered with a cold clammy perspiration, the radial pulse imperceptible, and the lips of a dark colour. A wound was found in the abdomen, and at the side lay a pool of blood mixed with feces; through the wound the bowels protruded. After the administration of some brandy, which appeared to revive the patient, the doctor proceeded to examine the wound. "A large clot partly filled the opening; this I removed, and near the inner angle of the wound was found an artery bleeding freely, which was secured with a ligature. * * * I then examined the protruding bowels carefully, and found a transverse section in the descending colon cutting through about half its circumference; through this opening I removed all the feces I could reach, and then brought the edges of the wound together, these being held by an assistant while I stitched them with the continued suture, making sure that the proper parts were in

close apposition." During the manipulation of the bowel the patient complained of sickness and a strong desire to vomit. "I cleaned the bowels as well as I could without using any water or cloth, and then pressed them back within the abdominal cavity, and on doing so observed that a quantity of blood gushed out; having satisfied myself that there was more in the abdominal cavity, I had some of the bystanders roll him on his side while I pressed the bowels back and lifted them up a little, bringing the most unclean parts of the bowel in contact with the flow of blood. I next laid him on his back, restored the bowels to their place, brought the edges of the external wound together, put a number of stitches in, washed it and put on strips of adhesive plaster, then soaked a piece of cotton in oil mixed with carbolic acid, and laid it on over all." After careful removal home on a door, iced water clothes were also applied and directed to be changed every five minutes. "I gave him small doses of pulv. opii to keep the bowels perfectly quiet, and allowed only liquid drinks for nourishment." The powders were continued for nine days. On the mornings of the 8th, 9th and 10th days 2 oz. of warm milk and water were thrown into the bowel, and on the 11th a small dose of castor oil was administered and produced one or two evacuations. More solid food was then allowed, and about the 16th or 17th day the cold applications were discontinued. "When pillowed up in bed sufficient external pressure was used to prevent bulging at the wound, and when he began to walk this was continued until the part was quite strong again." He made a perfect recovery. The dimensions of the scar are as follows: Situated "about 3½ inches below the navel, and two inches above the pubic arch the inner end of the wound crossed the median line about ½ an inch, and extended outwards about five inches leaving the outer end a little the higher, and about 1½ inch above the crest of the ilium."

Canthardin has been prepared from the fresh powder of the potato beetle, which yields about one and a third per cent.

To the Editor of the Canadian Journal of Medical Science.

DIPHTHERIA.

Having noticed by accounts from Canadian papers that diphtheria is very prevalent, and, to a large extent, fatal in Canada, I send you the formula that I have used since 1858. I have never lost a patient from diphtheria.

J. D. FRICKELTON, M.D.,
Fort Yale, British Columbia, Oct. 15, 1879.

FOR DIPHTHERIA.

℞	Potass. chlorat.....	℥j.
	Acid hychochloric dil.....	℥ij.
	Tincture ferri muriat	℥ijj.
	Aqua distill	℥xij.

Dissolve the chlorate of potassa well, mix and filter.

Dose, a teaspoonful every three hours, no fluid to be taken within fifteen minutes after. In very severe cases I use one part tinct. ferri and two parts of the above to swab the tonsils and throat until the patient can speak. If the fever is very high I add a few drops tincture aconite to each dose.

Translations.

HÆMATINURIA OR HÆMOSPERINURIA (HÆMOGLOBINURIA) FROM THE USE OF QUININE.

In the session of 18th Nov., 1878, of the Medical Society of Athens, Dr. Caramitsas, of the chair of special Nosology, read a memoir upon the subject expressed by the above caption, of which the following are the conclusions:—

1. Quinine has provoked a hæmosperinuria (hæmoglobinuria) sometimes attended by a febrile paroxysm, totally independent of malarial hæmaturic fever.

2. This hæmatinuria is provoked even by small doses of quinine.

3. Quinine is not only contra-indicated in cases of this diathesis, but is even decidedly prejudicial, and often dangerous; so that it is proper to interrupt the use of the quinine immediately on the occurrence of this hæmatinuria.

In all the seven cases observed by Caramitsas, the urine contained no blood corpuscles, but merely the colouring matter of the blood. (Galenos, num. 1.)—*Revista de Medicina Y. Cirugia Prácticas, Madrid.*

THE CANADIAN
Journal of Medical Science,
A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by sending reports of the proceedings of their Associations to the corresponding editor.*

TORONTO, DECEMBER, 1879.

TORONTO SCHOOL OF MEDICINE ANNUAL DINNER.

The sixth annual dinner of the Toronto School of Medicine took place at the Rossin House, Toronto, on November 13th, and, as usual, was largely attended by graduates, students and guests.

Mr. W. J. Cross, student, occupied the chair, and around him were seated, among others, Rev. Dr. Nelles (Victoria College), Mr. Goldwin Smith, Mr. Mayor Beaty, Prof. Croft, Prof. Ramsay Wright, Dr. Geikie (Trinity Medical School), Rev. Dr. Potts, Dr. Strange, M.P., Dr. Workman, Mr. Howells (United States Consul), and Dr. Macdonald (Hamilton). The faculty of the School was represented by Dr. Aikins, Dr. H. H. Wright, Dr. U. Ogden, Dr. Richardson, Dr. Thorburn, Dr. W. W. Ogden, Dr. George Wright, Dr. McFarlane, Dr. Oldright, Dr. F. H. Wright, Dr. Reeve, Dr. Graham, Dr. Zimmerman, Mr. Thomas Heys, and Mr. H. Montgomery. Among other medical gentlemen present were Dr. O'Reilly (General Hospital), Dr. Clark (Insane Asylum), Dr. King, Dr. Burns, Dr. Riddel, Dr. James Ross, Dr. McConnell (Thornhill), Dr. McLaughlin, M. P. P., Dr. Ray (Oshawa), and others. Mr. G. T. Duncan and Mr. B. B. Anderson acted as vice-chairmen.

The Secretary, Mr. Lewis E. Shepherd, announced that he had received letters of regret at not being able to be present from several prominent gentlemen, and read the following telegram from the students of Queen's College, Kingston, amid loud applause:—

"The students of the Royal College, imbued with that fraternal feeling which characterizes the generous medical student the world over, extend the right hand of fellowship to their brothers in Toronto. The position taken by the Canadian medical student at home and abroad affords reason for wide and sincere congratulation. May that spirit of generous rivalry for excellence in our profession continue to characterize our schools; and may the lustre of their reputation be untarnished by anything having even the semblance of dishonour!"

Mr. Irish, "mine host," of course was equal to the occasion, and had prepared a dinner which was indeed *comme il faut*.

The CHAIRMAN, in entering upon the list of toasts, said the Toronto School of Medicine had reason to feel proud of the success attending this their sixth annual dinner, and he rejoiced to see the faculty, graduates, and students brought together under such festive circumstances. He noted the recent improvements in the school, and the general advancement in its ways and methods of teaching, and assured the members of the faculty of the high esteem and admiration in which they were held by the students. The first toast was, of course, "The Queen," which was honoured amid cheers and the singing of the National Anthem. "The Governor-General and Lieutenant-Governor" having been heartily drunk, the Chairman proposed "The Active Militia," which brought Dr. Thorburn to his feet in reply. The marital doctor made a few very appropriate observations in reference to our volunteers, and thanked the company for their kind remembrance of them. Following came the toast of "The Dominion and Local Governments," coupled with the names of Dr. Strange, M.P., and Dr. McLaughlin, M.P.P.

Dr. Strange replied, and in the course of his remarks referred to the honourable positions that some members of the profession in Canada had obtained in the political arena. Dr. Tupper had become Sir Charles Tupper, and a member of the Dominion Government. Dr. Robitaille had been made Lieut.-Governor of Quebec, and Dr. Blanchet had been elected Speaker of the Commons. Dr. Strange advocated the registration in Ontario of all who, by virtue of British qualifications, held a license to practise in any part of Her Majesty's dominions, but also expressed himself in favour of reciprocity in this

matter. Dr. McLaughlin, M.P.P., also replied to the toast in suitable terms, advocating the right of Canadians to legislate for themselves in matters medical, and strenuously opposing the registration of British qualifications, so long as these qualifications did not represent in every branch an equivalent of knowledge to Ontario qualifications, and so long as reciprocity was not granted. The Mayor of Toronto answered for the toast of "The Mayor and Corporation" in his usual happy manner. To the toast of "University of Toronto and University of Victoria," Prof. Croft, Dr. J. H. Richardson, and Rev. Dr. Nelles replied. Prof. Croft referred to his long and pleasant connection with the Toronto School of Medicine, spoke of the early history of the University of Toronto (then King's College), and said that the occasion was probably the last of many opportunities he had enjoyed of addressing the students and friends of the Toronto School of Medicine. He hoped that the Government, in filling the vacancies caused by the retirement of Dr. McCaul and himself, would choose men renowned for their ability, learning, and scientific attainments, without any regard to nationality, politics, or creed. Dr. J. H. Richardson gave reminiscences of medical teaching in Toronto when he was the first matriculated student of King's College. Dr. Nelles congratulated the school on its success and prosperity, and referred to the gratifying position that Victoria College occupied, and to the benefits accruing from a theological training. His remarks were received with applause. He spoke of the advantages of the existence of two rival medical schools in the same city, as tending to stimulate them mutually to excel, and hoped that the rivalry would always be generous and healthy. Prof. Goldwin Smith was the first to respond to the toast of "Sister Institutions," and did so in his usual happy manner. He was followed by Dr. Geikie, the worthy Dean of Trinity Medical School, whose name was received with hearty and prolonged applause. Dr. Geikie thanked the company heartily for the compliment paid to Trinity Medical School in extending to their representative its hospitality, and for the cordial greeting that the toast had received. He trusted and indeed felt sure that the schools were animated by the feeling to in every way heartily co-operate in their duties of educating the medical students of Ontario, and spoke earnestly of the warm and friendly feeling with which those connected with the schools, both as teachers and students, should be mutually animated. Dr. W. T. Aikins and Dr. H. H. Wright replied to the toast of "The Toronto School of Medicine," referring to the history of the school in the past, the bright future that awaited it, and the duty of the Government towards it, and through it and other schools to the public at large. Dr. Aikins hoped that the Government would make the Toronto Hospital a free institution, and increase the facilities afforded for clinical teaching and study. Dr. Macdonald, of Hamilton, the president of the College of Physicians and Surgeons of Ontario, and Dr. Ross, the member for Midland and York, replied for "The Ontario Medical Council," and referred to the work of that body in the past and its intentions for the future, stating that the interests of the profession and the public in Ontario would be their care, and that it was their intention to carefully guard their rights and privileges in medical education and registration. Drs. McConnell, of Thornhill, and Riddell, of Toronto, responded for "The Graduates." Mr. J. Anderson spoke for "The Graduating Class." The Press, the Ladies, and the Freshmen were duly honoured, and the company separated at an early hour in the morning, having thoroughly enjoyed the hospitality of the students of the Toronto School of Medicine. During the evening, at intervals, Messrs. Christie, Miller, Duncan, Lesslie, Anderson, Meenie and others entertained the company with music and recitations.

THE ONTARIO MEDICAL COUNCIL AND BRITISH QUALIFICATIONS.

We are informed that, notwithstanding the fact that the Executive Committee of the Council last year felt themselves compelled to register a British graduate without examination, it is the intention hereafter to refuse to recognize this case as a precedent, and to compel all seeking registration to show that they have complied with the requirements of the Ontario Medical Act. Now that the Local and Dominion Govern-

ments begin to recognize the fact that if British legislation in medical matters is to control Colonial Legislation, the same rule may be applied to our legislative enactments as to admission to the legal and other professions, active measures will probably be taken to finally confirm us in the right we claim to compel every one seeking registration to conform to the provisions of the Ontario Medical Act. We congratulate the Executive Committee on the stand they have taken, and trust that they will maintain their rights. It is high time that the Ontario Medical Council should show that its function is to act and not to merely exist, not only in this matter but in many others. We hope to see also that, in accordance with their promises, the annual assessment will next year be *impartially* levied, for in the past it has been almost a dead letter.

Book Notices.

Perizia Sullo Stato di Mente di Passanante dei Professori Tommasi, Verga, Biffi, Buonoma, Tamburino (Relatore Tamburini), Reggio-Emilia, 1879.

Proceedings of the Louisiana State Medical Association at its Second Annual Meeting, 1879, with the Constitution and By-Laws. New Orleans, 1879.

Tobacco-Poisoning and its Effects upon the Eyesight. By A. W. Calhoun, M. D., Atlanta, Ga. From Transactions of Medical Association of Georgia.

The Treatment of Fracture of the lower end of the Radius. By R. J. Levis, M. D. From the Transactions of the Medical Society of the State of Pennsylvania.

Dominion of Canada—Manitoba and the North-West. Facts and Information for Settlers, with a map of the country. Montreal, 1879.

Atlas of Skin Diseases. By Louis A. Duhring, M. D. Part VI. Philadelphia: J. B. Lippincott & Co., 1879.

This part contains plates of Syphiloderma (pustulosum), Erythema Nodosum, Sebor rhœa and Eczema (papulosum), accompained by the usual explanatory text of each case. The high standard that has characterized the preceding parts of this Atlas is maintained in Part vi., which is excellent in every way.

American Health Primers: Eyesight and How to Care for it. By George C. Harlan, M. D. Philadelphia: Lindsay & Blakiston. Toronto: Hart & Rawlinson.

In this volume of the series published by Lindsay & Blakiston, the author tells the laity nearly all they should know about the eye. The anatomy of the organ and the physiology of vision are plainly and concisely described; and timely hints are given in regard to injuries and diseases of the eye, and the care of the eyes, and also in regard to the injurious tendency of modern school-life upon the sight. The important subject of optical defects and their correction is well explained; and altogether quite a fund of valuable information is provided, which it is to be hoped the public will duly appreciate.

Long Life and How to Reach it. By J. G. Richardson, M. D. Vol. II. American Health Primers. Philadelphia: Lindsay & Blakiston. Toronto: Hart & Rawlinson.

This little work is pleasantly written, and will prove interesting and useful to the profession as well as the general public. It takes up the causes of disease, such as excessive heat and cold, contagion, impure air, improper food, loss of sleep, parasites, etc.; and teaches us how to avoid them. It also gives excellent hints about suitable clothing, different kinds of baths, the various points to be considered in building our dwelling-houses, and proper ways of taking muscular exercise. The author concludes with a chapter on "Old Age and How to Meet it," giving valuable instructions to those whose vital powers an growing weak from this cause.

Memorial Oration in honour of Ephraim McDowell, "The Father of Ovariotomy." By Samuel D. Gross, M.D., LL.D., D.C.L., Oxon. Louisville, Kentucky, Printed by John P. Morton & Co., 1879.

We acknowledge with many thanks, to the

State Medical Society, the receipt of the Memorial Oration delivered by Dr. Gross, at Danville, Ky., at the dedication of the monument erected to the memory of Dr. Ephraim McDowell, by the Kentucky State Medical Society, May 14th, 1879. A well executed engraving of Dr. McDowell serves as frontispiece to the book. The oration is worthy of its eminent author and his subject; the man who so successfully advocated McDowell's claims as the first to perform the operation of ovariotomy, was well chosen to give an address on the occasion of the dedication of a monument to the memory of one who has been so grand a benefactor of the human race.

The Student's Guide to the Diseases of Women. By ALFRED LEWIS GALABIN, M.A., M.D., F.R.C.P., Assistant Obstetric Physician and Joint Lecturer on Obstetric Medicine to Guy's Hospital; Examiner in Physiology and in Obstetric Medicine to the University of Cambridge, &c., 1879. Philadelphia: Lindsay & Blakiston. Toronto: Hart & Rawlinson.

Referring to this little book of 370 pages, a friend remarked, "What's the use of that while we have Atthill?" and we also felt that the author was entering on a dangerous competion; but after carefully reading it through, we can safely advise our readers to go and do likewise. It does not embrace all the diseases and operations found in the larger works of Emmett and Thomas, but it does treat of a large proportion of the diseases of women met with in every-day practice, and the matter is so concise that the reader can easily comprehend the whole subject under discussion.

Chapter 1, on Physical Diagnosis, is very practical, and fully describes all the instruments usually required and the methods of using them in diagnosis; but we think the author is not emphatic enough in speaking of the danger of rapid dilatation of the urethra for the purpose of exploring the bladder. Indeed we think the practice should only be resorted to in cases of extreme urgency, and then with the full conviction that, however much care is observed, permanent incontinence of urine may follow. In chapter 2, on the Physiology of Normal Menstruation, he gives the modern views of Tyler Smith and John Williams as to disintegration and exfoliation of the mucous membrane, although he does not appear to fully accept them himself. In chapter 3, on Malformation of the Uterus and Vagina, while he refers to Emmett's plan of free opening and washing out the cavity of the uterus in cases of retention, he evidently prefers the old plan of very gradual evacuation; but we cannot dwell on these points. We find a great deal more to praise than to find fault with, in the book as a whole. It is very much like Atthill, and quite as good; and although we differ in a few points, we like it quite as well as that of the Dublin professor.

We heartily commend it to our readers as a faithful summary of the more common diseases of women, and a safe and practical guide to their treatment.

Clinical Medicine; A Systematic Treatise on the Diagnosis and Treatment of Diseases. By AUSTIN FLINT, M. D. Philadelphia: Henry C. Lea, 1879, Toronto: Hart & Rawlinson.

Prof. Flint introduces this his more recent work, to the profession by defining "clinical medicine" as being strictly the study of cases of disease, and as referring to two ends—diagnosis and treatment. The range of clinical medicine, he tells us, is not restricted exclusively within the limits of purely medical science; and in the work before us he proposes to furnish the practitioner and student with a guide to the investigation of disease, with reference to the two special objects stated above.

The plan of the work is, in the introduction, to devote attention to some general considerations; the work is then divided into sections corresponding to the divisions into which diseases are distributed, in accordance with the nosological arrangement generally adopted in the United States. Each section is prefaced with the symptomatology and the methods of examination relating to the diseases considered in that section. He gives directions under special headings for examining a patient, and expresses the opinion that the physician at the threshold of pro-

fessional life cannot be urged too strongly to begin at once to make daily records of important cases. Under the heading "Simulation of Disease," Prof. Flint thinks that decision should be reserved when there is reasonable ground for doubt; for he has known, as have others, sudden and fatal terminations when patients have been discharged from hospitals as malingerers.

There is much valuable information in the work, which, simply for purposes of diagnosis and suggestions as to treatment extends to a goodly-sized volume of 785 pages. Had some of the sections been reduced in their proportions and the space so gained been devoted to etiology, morbid anatomy and general and special pathology the result aimed at would have been attained, and the association of symptoms and signs, with cause and effect, secured.

It is a little doubtful if the present volume will add to Prof. Flint's reputation as an author or a teacher; it is furthermore doubtful if works of this class are well qualified, with the omissions above alluded to, to make the student a good practitioner, or better qualify the physician for professional practice, as relates to diagnosis and treatment.

TREATMENT OF TAPE-WORM BY SALICYLIC ACID.—Dr. Ridder reports two cases in which he gave salicylic acid to remove tape-worms, with the most satisfactory results. The mode of administration was as follows: An ounce of castor-oil was given in the morning, and the patient's diet was restricted during the day, so as to keep the intestinal canal as empty as possible. On the following morning half an ounce of castor-oil was given at 7 o'clock; at 8 o'clock 12 grs. of salicylic acid was given, and this dose was repeated every hour until a drachm of the acid had been taken; half an hour after the last dose, another half-ounce of castor-oil was administered. In one of the cases the worm was passed about 1 P.M., and in the other about 3 P.M.; both were examples of the tænia solium, and both were passed entire, with the head. After the passage of the worms the rectum was washed out with injections of water. The only unpleasant effect produced by the treatment was a slight nausea, which was not, however, bad enough to keep the patients from returning to work on the same afternoon.—*Allg. Med. Cent. Zeit.*

Miscellaneous.

Aloin hypodermically in solution of one part to twenty-five of very warm water produces the same purgative effect as when taken internally.

The veteran lecturer, Prof. Chevreul, has commenced his annual course on organic chemistry at Paris, although in his ninety-third year.

Mr. G. W. Callender, F.R.S., of St. Bartholomew's Hospital, London, died on Oct. 27th. Mr. A. H. Garrod, F.R.S., and Dr. Leared, F.R.C.P., died in October last.

ACONITE POISONING.—A case is reported in which three teaspoonfuls of the tincture of the root were taken. Recovery followed the use of tincture of digitalis, four hypodermic injections of 15 minims each being given.

LACTOPEPTINE.—This preparation, which is composed of pepsin, pancreatine, diatase (or vegetable ptyalin) lactic, and hydrochloric acid, and sugar of milk, has already acquired an enviable reputation, both in this country and abroad, in the treatment of many forms of dyspepsia, and in the digestive troubles in children. We have used it in a number of cases of marasmus, and it has been invariably followed by good results.—*National Medical Review*, March, 1879, Washington, D. C.

OCINUM BASILICUM, A NEW ANTHELMINTIC.—This plant, which is known in Buenos Ayres under the name *albahaca*, exerts a powerful action on intestinal worms, expelling them from their haunts with very great rapidity. The part used is the juice, and it is given in doses of about two ounces, followed in two hours by castor-oil. It acts more powerfully and certainly as a vermifuge than calomel, santonin, kousso, or kamala, and, on the other hand, posseses the great advantage of doing no harm if worms be not present, exerting then merely an aperient and disinfectant action.—*Allg. Med. Cent. Zeit.*

M. Maas, of Fribourg, has made a series of researches on the absorbing power of wounds, and the results which he has arrived at are partly opposed to the opinion admitted up to the present. A wound cauterized with the hot iron, nitrate of silver or nitric acid, absorbs like an intact wound: the absorption is much more rapid if the wound has been in contact with carbolic acid, as in Lister's dressing; it is nil in cases of cauterization with chlorate of zinc. In wounds treated openly, a crust is formed which at the end of six hours is impermeable: it becomes so only at the end of three days if the wound has previously been covered over with a wet dressing.—*Le Prog. Med.*

Signs of Death by Drowning.—MM. Bergeron and Montano (*Annal. d' Hygiene,*) have arrived at the following conclusions on the subject of death by drowning: 1. The presence of frothy foam, not only in the pharynx and the larynx, but also in the bronchi, is the constant sign of death by submersion, whether syncope or asphyxia predominated in the mode of death, and whether the individual was free in his movements or was thrown into the water after having been made insensible by opium or chloroform, or was partly suffocated, or was fettered in his action. This absolute constancy of the presence of foam, whatever the special condition in which the submersion occurred, is, in the opinion of the authors, the single sure uniform sign proving death by drowning. 2. There is always a certain degree of congestion, and sometimes subpleural ecchymoses are seen; but these ecchymoses, which give the lungs a spotted or speckled look, are unlike the punctate ecchymoses of suffocation. 3. The intensity of the hyperæmia, and the extent of the ecchymoses, are always in proportion to the efforts of the animal while struggling against submersion. It is the same also with the human subject, as has been verified in all necropsies made by the authors at the morgue in Paris during the last ten years. This fact permits one at a necropsy to learn concerning what passed in the last moments of life, to know whether or not the individual struggled long and vigorously during the act of drowning.—*British Medical Journal.*

Chlorate of Potash in the Hæmorrhagic Diathesis—By A. Harkin, M.D., Belfast.—Chlorate of potash, which is prescribed by the profession for a variety of diseases—such as scarlatina, throat-affections, low fevers, blood-poisoning, etc.—has qualities deserving a much wider application; and will yet, in the opinion of the writer, founded on extensive experience, be recognised as a potent remedy in the treatment of maladies depending on suboxidation, on defective nutrition, secretion, excretion, aeration, and molecular metamorphosis. Being mainly composed of oxygen and potassium, each of which is essential to the genesis of healthy blood, its chemical properties commend it to our consideration. In the hæmorrhagic diathesis, which is characterised by a diminished proportion of fibrin, a soft clot, an absence of the buffy coat, accompanied with a delicacy of structure in the capillaries and minute vessels, a remedy is required that shall increase the fibrin, add to the plasticity and chemico-vital elements of the blood and restore its coagulating power, as well as the contractile action of the capillaries; and thus destroy the dyscrasies, in which a slight wound may lead to excessive hæmorrhage, a trifling contusion to extensive extravasation. That this salt, whether given alone or in combination with iron, possesses the very desirable property of controlling the various developments of the hæmorrhagic diathesis, and that its persevering administration will neutralise the constitutional taint on which these ailments depend, Dr. Harkin hoped to establish by the relation of satisfactory cases, selected from an experience of its value extending over more than twenty years' observation. He generally ordered the medicine in the form one ounce of a saturated solution three times daily—one ounce of the salt to a pint of water; and, if iron be required, an addition of one drachm of the muriatic tincture to the solution completes the mixture. Administered in this proportion, Dr. Harkin had had the greatest satisfaction in the treatment of epistaxis; in hæmophilia; in hæmorrhage from the bowels, from the kidneys, from the lungs, from the stomach; in menorrhagia; in scurvy; and in purpura hæmorrhagica.—*British Medical Journal.*

On Condition of the Eye in Sleep and Disease.—The eyes have during sleep a position of equilibrium with a parallel drawn in the direction of the axis of vision; in going to sleep, however, they roll, or if disturbed during sleep by raising the lids, they converge upwards. Swinging and diverging movements of the eyeballs are only to be observed in adults during an abnormally deep sleep, and they are therefore to be regarded as proofs of a soporific condition. The pupils during a quiet and deep sleep contract to the size of a pin's head, but every stimulus which lessens the depth of the sleep without causing awakening, leads to a dilatation of the pupil, which occurs rapidly, but only slowly diminishes if the sleep is continued. The conditions are the same in the narcosis of chloroform and in the sleep produced by chloral; the deeper the soporific condition, however, with contracted pupils, the less is their reaction to a stimulus, and in the deepest stages the pupils may wholly fail to react to any stimulus. The cornea during sleep is covered with a viscid fluid, and the conjunctiva is slightly injected. This phenomenon is, according to Dr. Sander, dependent upon the sleeping condition of the brain, which causes an alteration in the secretion. In addition to these symptoms, the upper lid falls during sleep, the space between the lids becomes smaller, the eyeball is retracted, and loses something of its tension. If it be concluded that in the waking state the pupil dilates when it is covered by the eyelid, whilst it is seen that they contract during sleep in spite of this fact, the phenomenon can only be explained, according to Dr. Sander, by supposing that a stimulus acts during sleep upon the central nervous system. Although a satisfactory explanation of these facts is still required, we must at present be contented with the supposition that the state of the psychic organ has a direct and immediate effect upon certain appearances noticed in the eyeball. The condition of the eyes in pathological states is then considered. In the eyes of the dying whose skin is often covered with a clammy sweat, there is a lustreless look. The same loss of brilliancy is to be observed in patients suffering from acute delirium, in whom the saliva is viscid and is present in large quantities. So long as the pupils remain dilated the brain is not to be looked upon as in a condition of sleep, at any rate so far as the pupils are concerned. In nervous diseases the difference in the pupil are chiefly observed in paralytics, but it is often difficult to decide whether the affected side is that on which the pupil is contracted or not. One often sees during the waking condition that upon the same side as the pupil is contracted there is a narrowing of the interval between the lids, but quite a different relation is observed during the sleep of such patients. Occasionally no difference in the pupils is observed, or they contract during sleep very slightly or not at all; whilst pupils which are dilated during the waking state continue to be so during sleep, the pupil of the opposite side contracting as usual. A difference occurred during sleep in two cases of paralysis, which was not observable during the waking state. It is finally interesting to observe that the pupils in patients affected with paralysis diverge more frequently from the normal during sleep, than they show variations from the contraction which usually occurs from accommodation, convergence, or the influence of light.—*Arch. f. Psych.* ix. p. 129, *Ceutralblatt f. die Med. Wiss.*, 1879.—*Cincinnati Lancet and Clinic.*

Pills for Whooping Cough—(Bouchet).—

Pulverised Belladonna..	1 gramme (15 grs.)
Oxide of zinc	1 gramme (do.)
Extract of wild thyme..	2 grammes (ʒss.)

Mix and divide into 40 pills.

From one to six per day.—*L'Union Méd.*

Births, Marriages, and Deaths.

MARRIED.

On October 29th, Thomas Workman, Ottawa, son of Joseph Workman, M.D., Toronto, to Lillie, second daughter of L. Van Camp, Esq., of Berlin.

At Ancaster, on Oct. 23rd, Milton McCrimmon, M. D., to Margaret E., eldest daughter of William Temple.

On the 21st October, 1879, by the Rev. I. Tovell, at the residence of the bride's brother, U. Ogden, M.D., Toronto, Mr. Robert Armstrong, formerly of Milton, now of Montreal, to Millie E. Ogden.