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THE ECONOMICS OF PROSTITUTION.*

BY WOODS HUTCHINSON, A.M., M.D., DES MOINES, IOWA.

Reproduction is heaven's first law. The first commandment in Genesis is "be fruitful and multiply," and is of more importance than all the other ten put together. It is also much easier to keep. It has always been pretty generally observed without much assistance from Church or State; indeed in spite of a good deal of opposition from both at times. The attitude of so-called "morality" and religion toward this magnificent impulse is characteristic. The burden of their childish song is "Thou shalt not." They have much to say in reprobation, but very little in approval of a process, whose dignity and beauty they are utterly incapable of appreciating, and whose magnificent perfection they haven't the brains to comprehend.

Because, forsooth, it is a hard thing to control, it is to be condemned entirely, and scarcely a religion or a philosophy can be found which has not advised, nay, even ordered, its absolute repression, and held up celibacy as the ideal state. Here, as elsewhere, morality is far too exclusively engaged in shrieking—"Don't!!"

Fortunately, however, its counsels, commands, and threats have about as much effect upon the mighty sweep of this holy impulse as Dame Partridge's broom had upon the tide of the Atlantic. And because it dares to defy their petty authority and disregard their edicts, priest and philosopher alike proclaim it an outlaw, and a war of extermination is set on foot. This soon collapses and they decide to tolerate it. As a last stab, they unite in stigmatizing it as a low, "animal"

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appetite, and that alone was enough to damn it for centuries. But the latter term carries no condemnation with it nowadays. On the contrary, the fact of an instinct being shared by the lower animals is good presumptive proof that it is of great benefit and value.

We have reason to thank God that the sexual instinct, one of the noblest, holiest, and most elevating that stirs our bosom is an "animal" one, and consequently far older and stronger than we are. It is backed by the life of all the ages and throbs with all the pulses of nature.

Its worst, and I had almost said its only, perversions are *human*, and the results of "reason" and convention.

But this is not the only ban under which this wonderful faculty of ours is laid. Not only is its exercise to be barely tolerated as a concession to weak, sinful human nature, but its very existence is to be ignored as completely as possible, and an imitation instinct known as "modesty" has been invented and developed for that special purpose. Its principal function is to deny the existence of the very sentiment which called it into being. That it is a virtue of the finest water, all sorts and conditions of men unite in testifying, but it has one peculiarity so singular as to provoke mention. It begins just where innocence ceases. The first thing that our first parents in Eden did *after they had fallen* was to discover that they were naked and make unto themselves aprons of fig leaves. Between these two influences our grand sexual functions have gradually come to be regarded as positively disgraceful in themselves, and the parts concerned in them as something to be absolutely ashamed of. Even in scientific nomenclature they are styled the "pudenda," "things one ought to be ashamed of." As for the sexual appetite, the most important and overmastering impulse which moves the race, instead of its excesses alone being reprobated, it has become a sentiment, the movings of which no moral man would dare to avow openly, and which a modest woman would die rather than confess to her nearest friend. The impulse has been degraded so low that its mere possession is sinful. Is this a natural, healthy, rational attitude No, nor a moral one either. This feeling alone produces the very excesses it was invented to check.

And what is the real rank and dignity of this

despised and berated function? The most important, the highest, the holiest. Listen to that brilliant champion of evangelicism, Drummond, in his fascinating attempt to convince the Apaches of science that they are or ought to be orthodox Christians if they only knew their own province a *little* more accurately, and could take a broader view of its relations (in which he comes perilously near succeeding in a way he little intended). In the light of the Gospel, according to Darwin, he declares that "Sympathy, affection, fidelity, sacrifice, indeed all those noble traits included under the term altruism, spring from the reproduction instinct." Instead of being subversive of all morality it is the foundation-stone of it. With its feeblest and blindest flutterings altruism, the regard for others, is born.—"Ascent of Man," Henry Drummond.

Unselfishness, sacrifice, is no recent development due to "revelation," but goes back to the Ameba itself. From fission to parturition reproduction is self-sacrifice. And from the results of the process, from the care and nurture of "these little ones," have grown every atom of our morality, from earth-buried foundation-stone to heaven-soaring pinnacle.

In the light of the fifth Gospel we are just beginning to see the eternal truth of the saying of the first Gospel, "Suffer little children to come unto Me for of such (aye and *from such*) is the Kingdom of Heaven." True manhood, true womanhood, in the highest sense, is impossible without reproduction, while as for love, sympathy, philanthropy, sense of duty, it has simply created them. "The stone which the builders rejected is indeed become the head of the corner." Even the much lamented power of the sexual instinct is simply proof of the overwhelming importance and value of the function to the race, and the man or woman who can suppress it entirely is *less* than human rather than more, and will surely become *inhuman* sooner or later. The first duty of man is to perpetuate the species. The race has the first mortgage on him, and has had ever since he was a sea-weed.

If marriage is a failure it's because the breed is, and "the Caucasian is played out." Our whole social, ecclesiastical and political organization centres round this institution as nucleus. Civilization rises from the family, through the clan, the

tribe, the State, to the nation. "Charity," in the true sense of love-of-one's neighbor, literally "begins at home," and gradually broadens to include the tribe, the nation, the human race, in its scope. Indeed the family, the home, need but to be mentioned to be accorded the rank of *the* great and only true civilizing, humanizing, spiritualizing influences, and any nation which begins to weary of their control is marked for destruction.

Neglect of, or escape from, their obligations, is ruinous to all concerned. We all lament the sad lack of home-training so obvious in the children of to-day, but we forget that the lack of training suffered by the American parents of to-day on account of the scarcity of children is equally hurtful. This is the age of untrained parents, and they need training as much as children. The training of children works both ways, like mercy "it blesses him who gives as he who takes," and no man's or woman's education is more than half finished without it. Infancy, as Emerson has said, is indeed "a perpetual Messiahship."

And yet we constantly hear this magnificent sexual instinct of ours shrieked at and berated as if fornication, adultery, prostitution and rape were its chief and commonest results. Truly, "The evil that men do lives after them, the good is oft interred with their bones." The instinct (like all other natural ones) is at least a hundred times as powerful for good as for evil.

Let us consider now for a moment the attitude of etiquette and morals—too often interchangeable terms—towards the sexual function, in the light of the importance of the latter. There is only one word to describe it, it is simply *idiotic*.

In the first place they attempt and assume to absolutely taboo the whole subject, after the fashion of that other bird of equally brilliant plumage and gifted intellect, the ostrich. Not only the sexual organs themselves, but even the whole of the body which is covered by the clothing under which they are hidden is forbidden to be mentioned or referred to in "polite" society. According to its canons the entire body from the neck to the tips of the toes is a sexual organ. The origin of this lascivious refinement is obvious, for the mention of the regions which happen to be merely geographically adjacent to the forbidden parts, and which no pure-minded or well-bred person would dream of asso-

ciating with them, such as the chest, the abdomen, the legs, is as severely censured as that of the parts themselves. To such an insane pitch is this "nasty-niceness," as Aunt Tabitha calls it, carried that we have probably all heard reference to the "limb" of a piano, or the "limbs" of a pair of dividers.

While there is some doubt as to the true nature of much which passes for personal modesty, there is none whatever in regard to this society variety. It is a reticence born originally of a diseased imagination or a guilty conscience, discreditable to the individual displaying it, and disgraceful to the society which exacts it. Instead of being, as it mincingly affects to be, the very pink of refinement, it is the essence of vulgarity. "*Honi soit qui mal y pense*," as the chivalrous King Edward said when he picked up the garter dropped by one of the ladies of his court.

When we come to the absolute ignorance of their most important function, which this taboo entails upon many of our boys and girls, the case becomes a most serious one. How many of our boys have the true meaning, uses, and dignity of the sexual organs delicately, but plainly, explained to them before the age of puberty by their fathers, or how many of our girls by their mothers? I fear scarcely ten per cent. The first knowledge most of them have of this wonderful subject is from the filthy lips of some vulgar servant or prurient older school-mate. Is it any wonder that, driven by natural curiosity and the powerful impulse of awakening sexual consciousness, and ashamed to inquire of those who ought to be their natural instructors, they resort, in an ignorance, as pitiable as it is deplorable, to experiment upon themselves, upon one another, nay—even upon the lower animals. Truly, ignorance, is the very mother of vice.

But the most fatal result of this extraordinary attitude of both morals and etiquette is the extent to which the sacred obligations of exercising the reproductive function is destroyed. Our young men and young women of the "better classes" calmly debate the question as "to marry or not to marry." To be capable of such hesitation is a sign, not of self-control, but of degeneracy. After the alliance has been duly arranged for and formed, then the question is to be discussed whether it shall be permitted to result in anything

visible to the naked eye; and if so, after how long delay, and how many, or, more correctly, how few of them. And from these two sources spring the head-waters of the reeking stream of *Prostitution*. Its current is swelled mainly by the men whose incomes or positions are not regarded as "suitable" to marry on, and those who having married "can't afford" to have children or don't want to be bothered" with them. The man or woman who, for any such reason, absolutely refuses to assist in continuing the species has committed the unpardonable sin, and is henceforth fit for nothing but conversion into fertilizer. And nature will attend to the conversion with unerring certainty and comparative promptness if not interfered with. Marriage under these circumstances is little better than legalized concubinage. Indeed, the arrival at this decision is but the forester's mark upon the trunk which is beginning to rot at its core, and all her axemen will understand and obey its significance. It is her seal to the death warrant of the race and also of the individual.

Even that modified form of interference with her orders which consists in markedly limiting the number of children, is almost sure to result in serious injury to both individuals concerned and to the community as well. In the first place it is a fruitful cause of prostitution. Many a man is practically driven to the brothel by his own wife, and many another deliberately resorts to it from a cowardly and criminally selfish desire to shirk the responsibilities of manhood. Such a man ought to be branded like any other eunuch. In the second place it is easily the chief cause of abortionism, one of the most prevalent and deadly sins of the present day, whose evil results, both physical and moral, are rapidly coming to rival those of prostitution itself, a statement which needs no emphasizing in this audience. Thirdly, any and every means adopted, from onanism to tansy, result ultimately in serious injury to the nervous system of both parties concerned. Fourthly, it rears the children who are permitted to appear in an oligarchy or aristocracy instead of a democracy, and thus deprives them of one of the most valuable parts of their education in hardiness, self reliance and self control. Children who are less than three in a family are nearly always "spoiled."

In short, limiting the size of families has ever been and still is the chief and most potent factor

in the decay of nations and the fall of civilization. It is literally a sin against the Holy Ghost, for it is the thwarting and denying of our deepest and holiest instinct by filthy huckster-like mammon worship, a veritable making of our "Father's house a house of merchandise." And like such sin "it shall not be forgiven." Every nation in which it had notably prevailed has either stagnated or decayed. The grand old eagle-eyed, bull-chested Roman breed was literally extinct from its ravages centuries before the Empire fell. The stinking stagnation of China and India is largely due to it in the form of infanticide.

And to-day we can study the process in the yet living subject, in our sister republic, renowned alike for the small size of her families, the brilliancy and healthfulness of her prostitutes, the commercialization of her women, both in marriage and harlotry, the strict economy and thriftiness of her lower classes even in respect to manhood and feminine honor, the filthy pessimism of her literature, and the excess of her death-rate over her birth-rate.

The latest and most extraordinary development from the theory of the sinfulness of sex is that which is in these latter days brayed into our ears from every "suffragist" platform. That child-bearing, instead of a factor in woman's development, is absolutely a hindrance to her higher education, a clog upon her freedom and a mortal enemy of "culchaw." In fact, as a "club-woman" tersely expressed it to a friend of mine a few months ago, "Only fools bear children." There is only one thing which need be said in regard to this delusion, and that is, it has its uses. It prevents the continuation of the breed. Neither the "emancipated" woman at one end of the scale, nor the prostitute at the other, propagate their kind, and society has reason to be thankful in both cases.

What then is the excuse for this attitude of hostility toward the sexual impulses? Their excesses only. Only one of these is now to be considered, but it is generally regarded as the most serious. It certainly is prevalent enough. It has existed from the beginning of history, nay, of society itself; it appears in every race above savagery, in every clime, under every religion and form of government. It has the universality of an institution of nature. It has formed for itself a distinct class

or caste in every society, it has its tutelary divinity in every temple, its patron saint in every hagiology. It can even boast of an odor of sanctity. It has formed part of the ritual of most religions and has been more or less directly recognized, if not endorsed, by all. And yet it is distinctly a product not of nature, but of civilization. It is not "*animal*" but essentially *human*, like most of our vices.

No trace of it is to be found in any animal community, and a very little among savages. It is one of the "flowers of civilization," and at bottom commercial, "*bourgeois*." Instead of a sin of instinct, it is a sin against instinct, directly on the part of the female, indirectly on the part of the male.

To a woman it is a filthy trade, "the horizontal trade," as Heine calls it, with even more truth than sarcasm, while the man has about as much right to urge his "appetite" as an excuse, as would one who turns from healthful food to glut himself upon garbage. That the exercise of the sexual function is necessary to the health of the male at any age is a pure delusion, while before full maturity it is highly injurious.

Prostitution is a crime against nature. The attitude of the anthropologist, the naturalist, towards it may be summed up in one sentence: "It needs must be that offences come, but *woe* unto that man through whom they come." And yet it must perform some useful function, for it everywhere exists.

Another singular feature about it is its absolute irrepressibility and unmanageableness. Ecclesiastical, civil and military authority have all in turn utterly proscribed it and repressed it with ferocious vigor, and at times all three have been united in one determined effort to root it out, as in the Papal dominions for nearly two centuries, but the utmost they could accomplish was to change its form and increase its extent. They simply learned, what we in Iowa have just been learning again in the costly school of experience, that "prohibition does not prohibit."

Nor does the attempt at "regulation" fare much better. From a careful study of all the authorities I could secure and observation of the actual condition of affairs in several of the European cities, I am driven to the conclusion that the results of regulation are about as follows:

1. A small diminution in the number of registered prostitutes and a large increase in that of clandestine prostitutes; the decline of the brothel and the enormous multiplication of the grisette.

2. A marked increase in the number of men indulging in the vice, on account of diminution of fear of infection, and what is even more potent, removal of all risk of interference by the police, of arrest in some "raid," and the consequent possibility of publicity in the police-court.

In short, it puts the stamp of safety and respectability upon the whole business for both sexes. A Parisian or a Viennese "takes a woman" just as naturally and as frankly as a New Yorker or a Londoner takes a cigar or a dinner, and the prostitute of the former cities has almost as much self-respect and pride of station as the married woman.

3. It diminishes the marriage-rate of the community by rendering concubinage in some form safe, popular and economical.

4. It increases the ratio of illegitimate births, by obvious causes. Paris, the Mecca of this system, has the highest illegitimacy-rate in the world, twenty-six in the one hundred births or one-fourth of all.

Finally, it does not even diminish venereal disease, first, because the most fruitful breeding-ground of syphilis and gonorrhœa is *not* among prostitutes but among "clandestines," so-called "sempstresses," waiter-girls, chamber-maids, etc., and "amateurs" of all descriptions, and secondly, because the most rigid and skilful inspection can find no trace of disease in a woman who may develop well-marked primary or secondary symptoms before nightfall, and infect a dozen men before morning. In short, from the theological, the legal, and the philanthropic standpoint the case appears not only ruinous but well-nigh hopeless.

When, however, we turn and approach it from a medico-economic point of view, its aspect alters completely, and I venture to claim it as one of the grand selective and eliminative agencies of nature and of highest value to the community.

It may be roughly characterized as a safety valve for the institution of marriage. This, of course, does not imply approval or endorsement of the process, for though the escape of a certain amount of steam is beneficial to the engine, it is "a very cold day" for the steam that escapes.

It is simply a huge sewer, a garbage dump, a crematory, into which are hurled the least desirable elements of both sexes, degenerate men and degraded women, for conversion into more useful and less odorous materials.

I think it would be hard to find a subject upon which there is a more "plentiful lack" of reliable information and data of real scientific value.

This is unavoidably inherent in the nature of the case for obvious reasons. After a brief but bootless search through the authorities, I decided to appeal directly to the only class of men who possess both the information and the training to qualify them to speak with authority. I accordingly sent out a number of letters containing a list of questions to the leading physicians of New York, Philadelphia, Boston, New Orleans, St. Louis, Chicago, San Antonio, and San Francisco, also to a number of practitioners in smaller towns, thus including every section of the Union. Although the number of replies is small, about thirty, scarcely one-sixth of the total number of letters sent out, yet there is such a substantial harmony through them all that they form at least a most suggestive "straw" to indicate the direction of the current of professional opinion on this question. And this straw assumes the dignity of an indicator when we further add, that these thirty were those that felt themselves competent to speak definitely out of one hundred who replied to my letters, and that the list included such names as Gihon, Parvin, Edson, Price, Hare, Bolton, Bangs, Bernays, Dudley, and Chassaignac.

The first point to be considered in an economic study of this question is the motive which induces women to enter this profession. By this term I mean, of course, the dominant motive. It is freely recognized that no *one* cause alone impels any woman to this pursuit.

The following is the average obtained from all answers on this point:—

Love of display, luxury, and idleness	42.1	per cent.
Bad family surroundings	23.8	"
Seduction, in which they were innocent victims	11.3	"
Lack of employment	9.4	"
Heredity	7.8	"
Primary sexual appetite	5.6	"
	100.0	

This makes a showing strikingly similar to that

of the criminal class among men who are recruited mainly from the idle and shiftless among all classes, and from the defective classes. These two causes, including heredity, accounting for nearly seventy-five per cent. in the above table. It may be regarded as emphatically a *trade*, chosen from love of idleness, of luxury, and absence of sense of honor, or decency. Even Du Chatelet, after assenting that over sixty per cent. are driven into it by seduction, desertion, and want, admits in a lucid interval "C'est le desir de se procurer jouissances sans travailler qui est don ans le premier rang de causes." Again "C'est la vanitie et le desir de briller." Bitter as is the scorn and contempt heaped upon the prostitute she deserves it all, for she has in the vast majority of cases deliberately sold her birthright not for pottage, but for champagne and tinsel.

In reply to the question what is the chief and what is the second cause of prostitution, the results are, from twenty answers:—

	I.	II.
Love of display, etc.....	10	10
Bad family surroundings.....	4	10
Heredity.....	3	
Seduction.....	2	
Lack of employment.....	1	

Here the results are singularly uniform and strongly emphasized, the conclusions from the former table.

The next question relates to the class of society from which the mass of our prostitutes come, and I know of no point upon which popular impressions are more widely generally erroneous. The prevalent view appears to be what might be described as the "W. C. T. U." one, that its priestesses are all the victims of man's lust and base deceit, and drawn alike from the mansion and the hovel. Like most of the conceptions with which this body has blessed the world it lacks the support of facts.

Out of twenty-one answers to this question eighteen reply "lower," "lowest," and "poor and defective," "factory girls," or some equivalent term. One replies "lower middle" and two "middle."

Now as to the grade of education of these recruits, seventeen reply "very low," "uneducated," "analphabets," etc., and four reply "fair" or "average." This corresponds with the results

of Du Chatelet, who found that the prostitutes of Paris practically all came from the laboring or artisan class, and especially from those whose lack of intelligence and persistence makes them mere day laborers, "roustabouts," as the modern term is. By an elaborate examination of their certificates, he also found that of 4,470 prostitutes, 2,332 could not sign their names (fifty-five per cent.), and 1,781 could sign "but badly," leaving only 110, or barely two and five-tenths per cent. who could write at all, or legibly.

In short, as a professional man of extensive opportunities for observation, once remarked to me, "I have seen and studied thousands of these women all over the Union, and have never been able to detect any difference between them, which was not the work of the milliner and the upholsterer." As another of my friends expressed it even more tersely, "Out of thousands I have never seen one with good table manners."

There are, of course, exceptions to the rule, but the prostitute possessed of a spark of refinement, education or intelligence, is extremely rare, and usually very soon either marries or becomes owner of an establishment, and in either case retires from active practice.

And just here I would like to say one word in correction of what I believe to be another popular error as to the personality of a prostitute, and that is that she is usually beautiful. The advocates of the seduction-theory even go so far as to declare that she must be, otherwise no one would be tempted to seduce her, which is a fair sample of their logic. From a somewhat extensive experience with women of this class in the general hospitals of London, Paris, and Vienna, and a systematic study of the physiognomies of thousands of them upon the streets of the above cities, and of New York, Philadelphia, and Chicago, I have no hesitation in declaring that a handsome, or even attractive-looking prostitute is rare, and that the average of beauty is lower among them than in any class of women. The only important exception to this statement is the unchaste class of women among actresses and artist's models; who are no real exception, as they are almost forced into vice from the extreme exposure and pressure of their occupation. Whatever other evils the "fatal power of beauty" may be responsible for, it has no more to do with prostitution

than "the flowers that bloom in the spring." Men do not go upon the street or to the brothel to gratify their artistic sense for beauty any more than to seek intellectual companionship, but to get "the pound of flesh" that their lust demands, and the most "popular" prostitute is the one who is best capable of filling this demand to the utmost.

Even the majority of the most fashionable members of the demi-monde, mistresses of the wealthiest and most aristocratic "men-about-town," are creatures whom an anthropologist would trust about as far as he would a rattle-snake, and whom an artist would shudder to look upon. Here again is a point of resemblance to the criminal classes of whom the warden at Millbank Penitentiary declares that "a handsome face is a thing rarely seen in a prison, and a pleasing, well-formed face, never."

As everywhere else, so even here, beauty is a sign of purity and wholesomeness, a safe guide in nine cases out of ten.

The next question is, what class furnishes the largest proportion of its own members to the ranks of vice? In other words, what occupations seem to most favor this downward tendency? The unanimity upon this point is practically complete. Of twenty-two answers sixteen say "factory girls," "saleswomen," "waitresses," etc., and four say "domestic servants," and two "those too idle to have any occupation." In short, it is the women who are engaged in public occupations who are most in danger.

Again, we have the commercialization of women as a powerful factor in the production of this vice. It is based upon a trade instinct, pure and simple. Space does not permit me to enter upon the subject here, but I wish to record my solemn and sorrowful conviction that the woman who works, outside of the home or the school, pays a fearful penalty, either physical, mental or moral, and often all three. She commits a biologic crime against herself and against the community, and woman-labor ought to be forbidden for the same reason that child-labor is. Any nation that works its women is damned and belongs at heart to the Huron-Iroquois confederacy.

Now, as to the much-mooted question of the life-expectation of the prostitute after she is fairly embarked.

The "Talmage" view has been loudly trumpeted abroad, and as for once, it is partially correct, there is little needs to be said. The average of twenty-two observers gives the life duration at nine and five-tenths years, nearly double the popular one, but short enough. The same method gives the death-rate as seventy-five per cent. greater than that of normal women of the same station, but the causes of this increase are markedly different from those usually not only popularly, but also professionally, imputed. *Every* observer gives alcohol the first place as a factor, venereal disease comes second, morphine, cocaine, chloral, etc., third, suicide fourth, irregular hours and life, fifth. Alcohol would thus appear to be doing as useful work among women as it is among men. It is one of our greatest "missionary" agencies, and, unlike all others, its "conversions" are usually permanent.

Last of all comes the question of the effect of this institution upon the propagation of the species. Do women of this stamp leave descendants? Very seldom.

The deduction from all the answers is that barely three and one-tenths per cent. of prostitutes bear children at all during the ten years of their career. The birth-rate of healthy married women during such a term at this age would be nearly 200 per cent. Like all other evils, prostitution is self-limiting. The reason for this sterility is obvious. Disease of the sexual organs, syphilis, "preventives" of every description, abortions, and infanticide, easily account for it. Of the children born alive, very few survive, from ignorance, disease or neglect.

As to the proportion who marry the answers vary, widely ranging from 0.1 per cent. to 75 per cent., the average being 13.2 per cent., but upon the next point there is substantial agreement; *viz.*, that those who do are practically sterile, the answers as to fertility ranging from "barren," "very sterile," "very low," to "unfavorable," about 1.6 per cent., except one man who actually asserts that it is "the same."

The proportion who permanently reform is variously estimated at from "one in a million" to 30 per cent., but the average is low; *viz.*, 6.8 per cent.

This is probably not far from correct, for even the managers of Bethels and reformatories for this

class sorrowfully admit that the number who come under their care are but a very small proportion of the entire class, and even of these only a moiety are permanently improved. The secretary of a large society of this sort (Mr. Talbot) estimates that in the eighty years previous to 1845 only 14,000 or 15,000 women had been within the walls of all these institutions in London, or less than 200 per year.

To sum up then from the female side of this institution, our conclusion would be that it is concerned principally with the most worthless varieties of women, the degenerates or criminals, and the idle, the mercenary and shameless of the working classes, women in short, whom the community can well afford to spare.

That these women, when fairly in its grasp, are practically, absolutely, prevented from propagating their kind during their career, and rapidly destroyed if they remain in it. That very few marry, and those who do so are barren in a high degree, in short, it is an eliminative agency of high value and wonderful efficiency for first sterilizing and then rapidly destroying the worst specimens of the sex—women whose "reform" and child-bearing would be a curse to the community. No need to spay the prostitute or castrate the criminal, they'll do it themselves if they are just given a little time.

What now is the effect of this vice upon the men who indulge in it, and, through them, upon the community? Practically the same, namely, the sterilization of the unfit. The more one studies the venereal diseases the more one becomes impressed with the opinion that their deadly virus is aimed, not at the life of their victim, but at his or her power of reproduction. In fact, both gonorrhœa and syphilis are very seldom fatal in women, and only exceptionally so in men, popular and even professional impression to the contrary notwithstanding. But they are most effective sterilizers for a period varying from six weeks to six or seven years, and not unfrequently totally destroy the reproductive power. This is strikingly true of syphilis. Suppose a man becomes infected at a brothel. Once this disease has appeared, for a period of at least two years, not merely his semen and genitals, but his saliva, his lips, every sore upon his body, every drop of his blood, is actively contagious. He must refrain from sexual

intercourse, or, if he disregards this rule, he will not only infect his wife with the loathsome disease, but what is more significant, any conception resulting, in the great majority of cases, will terminate in a miscarriage, a still-birth, or the production of a child which dies of syphilis within six months of its birth. And this history repeats itself until the taint gradually dies out of the blood, a period of at least two years under the promptest and most skilful treatment, but which, under neglect, or with a later infection of the wife, may extend to five, six, or seven years. This may seem an overdrawn picture, but Turner declares that 85 per cent. of syphilitic children die before the sixth month. Kassowitz gives the percentage of children *born of syphilitic parents*, either still-born or dying within six months, at 55 per cent., and Sturgis reports that 71 per cent. of the children of such parentage, born in the Moscow Hospital, die within that period. By and by the virulence of the poison dies down, a child is born that barely escapes with its life, another by a little wider margin and so on till healthy children can be produced. But what of these who escape? Stunted: bleared-eyed, pitiable, with sunken noses, opalescent cornea, scarred mouths, and notched teeth, they are degeneration incarnate. I have seen hundreds of these poor creatures in our large hospitals, the oldest children of their families, literally victims of "the plague of the first-born," the first of three, five, even seven, or eight fetuses and children to survive the attack of the virus, and I have yet to see one who has passed thirty years of age.

Iarnowsky reports a suggestive group of three couples infected by syphilis who produced twenty-two children; of all these there came only one healthy adult man. Syphilis is more merciful than the Jehovah of the Decalogue, for it usually suppresses the second generation before it acquires consciousness, and permits no third generation to appear to be "visited with the iniquities of the fathers." Like all other diseases, it is self-limiting in the individual or the species. It is, however, largely a question of intelligence and self-control on the part of the original victim, for simply by strict abstinence and a rigid adherence to the old saw, "A night with Venus, a moon with Mercury," for two years syphilis can be as certainly and almost as completely cured as scarlatina or typhoid. And this not only as regards

the secondary or venereal stage, but also as to the dreaded tertiary, or individual Nemesis, plague, with its Pandora's box of locomotor ataxia, cerebral gumma, "g. p. i.," meningitis, retinitis, laryngitis, etc. Thus not only as a sterilizer, but also as an encourager of intelligence, in popular language, as a "fool-killer," it has few equals.

But what as to the other, milder and far more common venereal disease, gonorrhœa? This has usually been regarded not only popularly, but also professionally, as a mere trifle, entailing generally some temporary discomfort, but of little more real importance than an ordinary "cold in the head." It is purely local, and usually cured in six or eight weeks, and most men can easily restrain themselves for that length of time, indeed the disease saves them all trouble on that score during the first half of the period. But what of the harvest?

There is a change in professional feeling which bids fair to amount to a revolution.

From the bacteriologic laboratory on the left wing comes the startling declaration that the "cure" of gonorrhœa is merely the establishment of toleration of the presence of the gonococcus, on the part of that individual's urethra, and that its discharges still remain virulently contagious to healthy genito-urinary passages. In fact, that the seminal fluid has been found swarming with gonococci, a year or more after the "cure" of gonorrhœa, of which I have just had a painful case brought under my own observation. There is a sharp rattle of musketry from the right wing, where the reckless laparatomist brigade in their fierce pursuit of the deadly ovary and the treacherous tube have suddenly stumbled upon another ambuscade of the enemy. It is our old friend the gonococcus, who their scouts declare to be concerned in eighty-five per cent. of their salpyngitis onslaughts. Here again venereal disease, *plus the laparatomist*, is a most efficient sterilizer. And at last we have reason to be thankful even for celiotomy.

But what of the great mass of veterans in the centre, the clinicians, the real infantry of the line in the army of medical progress, the Ironsides of the host of science, who indulge in no boastings or triumphing before the battle, or pyrotechnics of any description, or guerilla atrocities of any

sort, but simply move steadily, irresistibly forward, holding every inch of ground they gain. From every division come reports of serious casualties, of life-long and even fatal strictures, of cystitis, of young men crippled by gonorrhœal rheumatism, of thousands of little children with eyes sightless from gonorrhœal ophthalmia, of endometritis, of cellulitis, and more significant yet, of orchitis, of testicles which retain their form but not their function, and recently of semen which is swarming not with spermatozoa, but with other micro-organisms which have no tails and cluster in groups.

More than one of the leaders goes so far as to send the despairing message: "It is doubtful whether gonorrhœa is ever cured!"

Here again, "justice may move with a leaden foot, but she strikes with an iron hand."

To sum up, the whole mechanism of prostitution is an engine of deadliest efficacy in sterilizing and ultimately destroying the worst elements of both sexes. To say that it also involves fearful and widespread suffering and damage to innocent women and children, would be as true as it is pitiable and harrowing, but I firmly believe that this is much less both in extent and painfulness than is usually stated, and is from a purely economic standpoint only, far overbalanced by the benefit resulting to the race. "A companion of fools shall be destroyed" is no vengeful threat, but a simple statement of a stern, necessary natural law. Pain, disease and death are hard to bear and harder to look upon, but they are among the greatest benefactors of the race.

The only way to check its action is to reduce to its "anatomically necessary" limits the class upon which it is sure to act. Men should be taught the sacred duty and true dignity of reproduction; that any attempt to avoid this duty brings its own punishment. That their sexual powers belong not to themselves, but to the race, and every exercise of them must result ultimately in either a pregnancy or syphilis. That they cannot hope to enjoy the privileges and pleasures of manhood and shirk its responsibilities.

Women should be taught to trust their instincts, for in them the maternal impulses is stronger than life itself. That like every other natural instinct, it is of highest benefit not only to the race but also to the individual. That any attempt to

thwart it, or even failure to give it proper development, will result in either dwarfing or decay.

The freedom of intelligent, refined conversation upon sexual subjects ought to be broadened, it should no longer be considered indecent to speak plainly. Most of the flavor of obscenity which hangs about the discussion of sexual matters is due to this very restriction. No excuse or danger should be left for boys and girls on the grounds of ignorance of this important function. In other words, intelligence, altruism, true refinement, should be promoted by every possible means, and Nature will continue to assist us by emphatically discouraging their opposites.

Above and beyond all we should foster, glorify, deify if necessary, the one instinct in man's bosom which can master the sexual, the highest, the holiest, the strongest of which he is capable. His love for the one woman who is or is to be all the world to him. Once touch this spring and he is safe. Well may all of clearest, and deepest vision among us, the poets, never weary of singing its praises. The age of chivalry should be brought back in nobler, truer form.

Lust laughs at opposition and exults in danger, but sinks ashamed at the whisper of love. Impress upon every man not his own danger, but that of his wife that is to be, of his children yet unborn. Nay, further, make him to see that the last insult he can offer to the one for whom he would cheerfully lay down his life, is to make, in the burning words of the apostle, "her members the members of a harlot" and prostitution will disappear from the face of the earth.

HOW VAGINAL DOUCHES SOMETIMES CAUSE SEVERE ACCIDENTS.

BY DONALD B. FRASER, M.B., M.R.C.S. ENG.,
STRATFORD, ONT.

On June 4th ult. attended Mrs. W. in her confinement and instructed the nurse to give her a vaginal douche of hot water twice a day.

A week later received a message to visit her, when I was told by the nurse the patient had an abnormal condition of the vagina interfering with the use of the syringe. I then gave the patient a vaginal douche with the syringe the nurse had employed, but met with no difficulty or abnormal

condition. To make sure everything was right I made a digital examination, and found cervix very low down, os widely dilated and much relaxed, allowing index finger to pass easily through it into cervical canal.

Requested the nurse to make a similar examination to ascertain if the structures in the vagina had not been mistaken by her for an abnormal condition of it as well as the obstacle to the introduction of the syringe encountered in attempting the last douche.

She acknowledged them to be one and the same, and related how she had felt the point of the syringe pass through a ring-like structure—the os—while introducing it to give the last vaginal douche.

On this occasion it was the ordinary enema syringe with long nozzle, measuring not less than five inches, that was used, and the nurse kept the point of it well to the front in the vagina, making it more difficult to avoid the os.

The patient maintained she felt the injection each time in the uterine cavity, and while receiving the last treatment complained of a good deal of pain, discomfort and a feeling of faintness, followed by a considerable hæmorrhage which greatly alarmed both patient and nurse.

I now realized the cause of unpleasant, troublesome and dangerous symptoms in certain cases arising from the improper use of the syringe in connection with the vaginal douche. I remember this same patient, while receiving similar treatment after one of her previous labors, experiencing suddenly excruciating pain and great shock that produced an alarming state of collapse followed by a very severe attack of metritis that almost proved fatal. After most of her labors the patient suffered from somewhat similar attacks, while the vaginal douche was being given, but they were not so severe.

I have a very vivid recollection of another patient who had an abortion about fifth month, and for whom I ordered a vaginal injection of hot water. The nurse had scarcely begun administering the douche when the patient suddenly felt a severe pain, became pale, gave a loud scream and exclaimed she was dying, lost consciousness and passed into a condition of dangerous collapse.

An urgent message brought me to the bedside of the patient in a few minutes—found her almost

pulseless, extremely pale, gasping for breath, very restless, and in fact nearly moribund.

Sent for a medical colleague, and by our united efforts succeeded in rallying her, and restoring consciousness after a time of great anxiety. After this unfortunate occurrence the patient suffered from a severe attack of peritonitis as well as more or less metritis. She made a slow convalescence, and would never again have a repetition of the vaginal douche.

Such cases have been observed, most likely, in most medical men's experience. The conditions necessary to cause this accident, I believe, are far from uncommon, hence we should be careful not to expose our patients to the dangers involved in this occurrence. Every nurse should be taught to give a safe and efficient vaginal douche, and be made aware of the fact that the point of syringe may be passed through the os into cervical canal in a certain number of cases, and especially if the long nozzle is employed. Under such circumstances the patient receives, instead of a vaginal an intrauterine douche, and is exposed to the dangers incident to the Procedure.

The fountain syringe with short nozzle is to be recommended to nurses, and they must be made familiar with its safe introduction and manipulation as well as with the accidents which may follow its use. The point of syringe is to be kept well posteriorly in the vagina to avoid the os during its introduction. This kind of syringe is safe, easily kept clean, aseptic, and in good working order.

PREFERABLE METHOD OF STERILIZATION AND STORAGE OF CATGUT.

BY J. COPLIN STINSON, M.D.,

Late House Surgeon Post-Graduate Hospital, New York,
Hamilton, Ont.

So many unsatisfactory results have followed the use of improperly prepared catgut, as evidenced in circumscribed or diffuse inflammation and supuration, that it is highly important that the surgeon should obtain the most thoroughly safe and reliable suture material. Taking the ground that catgut furnishes this ideal, we proceed to demonstrate a method by which we secure its sterilization without impairing its durability or strength. Before taking up the sterilization of

catgut, we would suggest that in purchasing the material, the preferable is that put up in bowlines,* each one yard long and rolled separately in bunches, as sold by Keller, Nassau St., New York. We select the bowlines because they are more easily prepared and more handy to manipulate in operations.* We thus do away with reels which are cumbersome, besides the solutions and heat having free access to each particle of the material thoroughly permeates the tissues of the bowlines: whereas if the gut is on reels the deeper layers are not so completely influenced; again, during an operation a sufficient number of bowlines can be removed from the glass storage bottle with a pair of sterile forceps without infecting the rest of the catgut.

The method to be commended:

1. Place bowlines in pure ether for one week*.
2. Place in a glass vessel with a glass or screw stop (sterilized), containing 1 in 2000 corrosive sublimate in pure ether for one week.†
3. Place catgut in a bottle with a screw top (sterilized), pour in absolute alcohol to cover gut. Screw down top tightly and put bottle in a glass sealer containing water which reaches nearly to screw top of catgut bottle, replace top on sealer which is set in water to be heated to the boiling point, and maintained at this temperature for 15 minutes; at the lapse of which time catgut is ready for use. During the boiling a small quantity of the alcohol evaporates and there is no danger of an explosion even with the top screwed down tightly. Only a comparatively short portion of the surgeon's time is engaged during the process already described, in return for which he has an absolutely sterile material. After the first step every precaution must be taken to insure surgical asepticism, such as sterilization of all articles used in the process, and antiseptic preparations of the hands.

The *modus operandi* is easily explained:

The ether thoroughly removes the fat from the catgut. The bichloride of mercury dissolved in ether disinfects, increases the durability and does not lessen the strength of the material.

As to the alcohol, it is well known that it is not a germicide,‡ if it contains germs the latter will

*Bowlines were first used as routine by R. T. Morris, New York.

†R. T. Morris' method of sterilization of catgut.

‡Sternberg's Bacteriology.

live but not multiply; boiling the catgut in alcohol removes all traces of the bichloride and destroys any germ life which may exist in it, thus constituting it the ideal storage fluid. Catgut prepared by the above method is thoroughly sterile, can be kept so for many years, and what is also of great importance, does not require to be chromicized, as it remains about as long in a wound without being absorbed as the chromicized material.

Selected Articles.

TUBERCULAR MENINGITIS AND CEREBRO-SPINAL MENINGITIS CONTRASTED.

Two children admitted to the hospital on the same day (May 8th), were seen by you soon after admission, both evidently affected with some disorder of the brain. Both cases have now run their course, and you saw in the *post-mortem* room, both of the brains. The symptoms were discussed, compared, and contrasted at the bedside, and the true diagnosis was arrived at in both cases; but the subject is so important that a review of the points which led to the diagnosis may be useful to you, now that you have seen the actual state of matters after death.

The case of the older child, a boy eleven and a half years of age, presented little difficulty. We had here a typical case of tubercular meningitis—typical so far as we can speak of types in this disease; for you will soon find that cases differ from each other, and from the “types” you choose to create in your own minds; deviations from the ordinary cause, occur from certain of the usual symptoms being absent, or from certain peculiarities being superadded. In this case, for example, squinting which is one of the commonest symptoms was, and apparently had been, entirely absent. On looking at him, we found a bandage on his arm, and on inquiry, we found he had been treated at the out-patient department for a tubercular abscess of the elbow. This was a point of capital importance in the diagnosis, and made it almost superfluous to inquire into his family history or his previous health, or for the evidence of recent falling off in condition. These points are of great value in diagnosis in many cases, and indeed this boy's mother was said to be dying of “decline,” but in his elbow there was obvious evidence, apart from all such inquiries, that our patient himself was affected with tubercular disease; and in presence of grave brain symptoms, the presumptive probability of tubercular disease in the brain, or its membranes, was overwhelming.

He lay almost unconscious, and showed little signs of consciousness even when disturbed. As already stated, there was no squinting; but his pupils were not natural. They were neither very contracted nor very dilated, but they did not respond normally to the stimulus of light. At the first application of light, you might chance to see a contraction sufficiently marked to make you think they were acting normally; but with the light still applied, you would see them dilate again, and indeed go through various phases in this way. This “osculation” of the pupil, as we call it, is a common feature in tubercular meningitis. On watching the effect of the respiration on the pupil, we could occasionally see, in a slight form, what I have called attention to in a communication on Cheyne-Stokes breathing; during the deep inspirations a dilatation was noticeable; a rhythmical dilatation and contraction, with the inspiration and expiration, may sometimes be seen in cases of Cheyne-Stokes breathing whether due to renal, cardiac, or cerebral disease.

In cases of tubercular meningitis we may have the most perfect development of Cheyne-Stokes breathing; but usually, the breathing is more of the irregular type, with recurring long-drawn sighs.

On drawing a nail or a pencil over the skin of the abdomen, I showed you a moderately well developed “*tache cerebrale*.” But you must not allow yourselves to be misled by this name into thinking that this is a pathognomonic sign. We get it in typhoid fever, and various other diseases, usually no doubt with signs of nerve disturbance; at present I have in the Western Infirmary the most perfect specimen of it I ever saw, in a girl with Graves' disease.

The abdomen in this body was flat, or it might almost be described as retracted; and this combined with the emaciation, which brought the pelvic bones into prominence, gave the appearance of the “boat-shaped belly” which you have heard of under this or other allied names. The bowels in this case, as is usual in tubercular meningitis, were constipated, both before admission and while in the ward.

Vomiting did not seem to have been a feature in this case; certainly none occurred in the ward.

The temperature was higher than normal, but the degree of fever was not great—100° to 101° in the rectum, the pulse was usually high, 130 to 168 per minute. The examination of other organs pointed to some mischief in the lower part of the right lung.

The course of the case after admission was steadily downward, and he died on May 12th, without any marked elevation of temperature (100° F.) At the *post-mortem* examinations, as you saw, the base of the brain was coated with exudation, the sylvian fissures were glued together on each side, and on lifting up the lobe, the

granular appearance of the tubercles was recognizable. In the right lung a patch of pneumonic consolidation was seen in the lower part, where liquid râles had been heard; and a cheesy mass of bronchial glands were also found.

In comparing the other case we found some similarity, but many points of contrast also. There was a marked internal squint of the right eye, and also a notable retraction of the head; both of these, with an obvious impairment of the consciousness and a tense fontanelle, at once suggested meningitis. But the diagnostic significance of the squint was largely affected by the history of its having been there for three months, while the brain symptoms were only supposed to be of at most three weeks' duration. Before these symptoms came on there was a history of what was called "congestion of the lungs," taking the illness back for six weeks before admission. But apart from the squint, the partially unconscious state, and the retracted head, pointed to some brain affection; the question, however, arose what kind of affection this might be? The pupils were equal, somewhat contracted at times, but sometimes moderately dilated, and a response to light, in the left pupil especially, could frequently be obtained. The child was fairly well nourished, and the history seemed to suggest some acute febrile illness arising out of the so-called congestion of the lungs. The temperature was high on admission (103.4° F.) and continued so (101° F. to 103° F.) There was a history of diarrhœa, and the bowels were loose on admission and continued so; this is of very unusual occurrence in tubercular meningitis, and although it does happen occasionally, it always makes one hesitate in the diagnosis. The abdomen, far from being retracted, was actually rather tumid. The persistence of high temperatures after comatose symptoms become developed in tubercular meningitis is quite unusual; and the pyrexia, the diarrhœa, and the tumid abdomen made one feel inclined to hope that the brain symptoms might be due to the nervous disturbance of enteric fever, as this frequently resembles tubercular meningitis. Even retraction of the head occurs in this fever, as I witnessed last winter in the case of a girl in my ward who recovered after a severe illness, characterized by diarrhœa and other diagnostic symptoms. In her case the retraction of the head was very marked and persisted for some time. For a few days I actually thought we might see this favorable view of the baby's case confirmed as the temperature came down a little. The diarrhœa moderated; at the same time the nervous symptoms improved, and the retraction of the head became less extreme, and a week after admission the child was conscious enough to play with toys (May 15th). The presence of a *tache cerebral* in this case did not, as I explained, exclude the diagnosis of enteric fever.

Eight days after admission (May 16th), the hopes of improvement were disappointed by the supervention of sickness and vomiting, and by an increased retraction of the head; this became more and more marked, and for four or five days before death it assumed the feature of a typical opisthotonus, as I pointed out to you. With this aggravation the unconsciousness became more profound, but the temperature still remained high (102° F.) With the disappearance of the partial improvement and the aggravation of the nervous symptoms, one had to give up the hope of the illness being due to the nervous disturbance of enteric fever; but all the points against the diagnosis of tubercular meningitis still remain in force, so I was led to think of some other fever with nervous symptoms as the cause of the illness, and cerebro-spinal fever, as it is sometimes called, or cerebro-spinal meningitis seemed to afford the most likely explanation of the symptoms. When the reaction of the head passed into a regular opisthotonus, the existence of this seemed almost certain. The feeding of the child, as it lay on its side with the head powerfully retracted, was very difficult; and regurgitation of the fluids through the nose repeatedly occurred. The child died on May 22nd, fourteen days after admission. Tremulous movements of the arms occurred four or five days before death, and when the opisthotonus was most marked, some slight spasm of the legs, with pointing downwards of the toes, was recognized. There was no marked spasm of the hands, but the thumbs were often drawn across the palms. No pronounced convulsions occurred. The temperature ran up to 105° F. just before death.

The examination of the brain showed copious exudation of the gelatino-purulent type, over the whole surface, especially abundant on the convexity of the brain in the sulci. In this case a large amount of exudation was seen at the base and especially in the region of the optic chiasma, a region usually little affected in this form of meningitis. The spinal cord showed no exudation on the anterior surface, but the whole of the posterior surface, from the lower end of the cervical enlargement to the upper part of the lumbar enlargement, was coated with a thick layer of the same gelatino-purulent exudation.

Unfortunately permission was not obtained for examination of other parts of the body. It would have been important to see the state of the chest, particularly as there was a recent history of "congestion of the lung." Special interest attaches to this subject as the microbe of cerebro-spinal meningitis is said to be the same as the pneumonic. In my own practice, last winter, a man died in the height of pneumonia with high delirium, and at the *post-mortem* examination we found meningitis of the convexity. In another case I had some years ago, after the crisis of pneumonia seemed to

be fairly established, a man became affected with alarming nervous symptoms, due no doubt to cerebro-spinal meningitis which was found after death.

In Glasgow, cerebro-spinal meningitis is a rare disease; sporadic cases occur at times, but no epidemic has been recognized here. In Angerline, Dr. William Frew described a small epidemic of this disease in a paper in the *Glasgow Medical Journal* for 1894; and he tells me that lately he has been seeing some cases in the district about Kilmamock.—James Finlayson, M.D., in *Arch. of Pediatrics*.

A BULLETIN ON THE PREVENTION OF DISEASES AMONG INFANTS.

ISSUED BY THE BOARD OF HEALTH OF THE CITY OF NEWARK, NEW JERSEY.

This circular is advisory, and deals only with the prevention of disease. The care and treatment of a patient should be referred to a physician.

A large proportion of all who die are infants one year of age. By far the larger number of infants who die have been fed artificially. It has also been demonstrated that this mortality is chiefly caused by errors in infant feeding.

During the first year infants were designed to subsist on animal food, (namely, human milk;) on this they usually thrive. When deprived of their natural food, the physician, the chemist, and the mother, have been taxed to their uttermost to provide a suitable substitute.

The results of careful investigation and long experience have proved that fresh cow's milk, when it has been modified to correspond to woman's milk, and then, by some proper treatment, preserved from spoiling, is the best substitute food for the infant during its first year.

ARTIFICIAL FEEDING.

The average stomach of a child at birth holds, when full, about two tablespoonfuls.

The increase in the size of the child's stomach is in proportion to its growth or weight.

The health and vigor of after life is undoubtedly laid in the first year, by proper feeding.

Proper infant feeding usually makes muscular children, with nerve force, not always fat ones.

When a food is substituted for woman's milk, it should contain only what nature designed, and in the same proportions.

Nature does not supply bread or crackers, or meat, or granulated sugar; and these should not be given to the infant.

Cow's milk, when properly prepared, furnishes a whole and sufficient diet for an infant, and supplies all it needs for robust health.

Fresh milk should constitute the principal article of food for the infant, even after weaning, and during the greater part of childhood.

No infant, under one year of age, can easily digest cow's milk, until changed; it is weaker in some things, and stronger in others, than woman's milk.

Failures in artificial feeding are chiefly due to three causes. First: Over-feeding. Second: The use of food which is either too strong or too weak. Third: The use of food which is changing or has already spoiled.

The following receipts will change cow's milk into food mixtures, suitable for healthy infants, up to one year:

MODIFIED MILK FOR INFANT FEEDING.

MADE WITH ONE QUART OF BOTTLED COW'S MILK.

For the amount and number of feedings in a day, consult a doctor.

First 6 months.

The top milk (cream) $\frac{1}{2}$ pt.
Boiled water, 1 pt.
Milk sugar, 700 grains.

From 6 to 9 months.

The top milk (cream) 1 pt.
Boiled water, 1 pt.
Milk sugar, 900 grains.

From 9 mos. to 1 year.

Top milk, $1\frac{1}{2}$ pts.
Boiled water, $\frac{1}{2}$ pt.
White sugar, 3 teaspoonfuls.

Dissolve the sugar in the hot water, add the cream, and divide in separate bottles, putting one feeding in each. Cork them with clean cotton.

One tablespoonful of lime water should be added to every gill of the food.

To preserve the food from spoiling, set the bottles filled, and corked in boiling hot water for thirty minutes. A three-quart covered pail will answer.

THE PROPER CARE OF MILK.

Milk is a delicate animal fluid, highly sensitive to exposure, and quickly spoils unless it receives great care.

Milk is spoiled by the bacteria which falls into it, and which set up fermentations due to their presence in it.

Vessels for holding milk should be made of earthenware, glass, or porcelain, and always be provided with covers.

In open vessels, milk should be counted unclean, for it is thus exposed to invisible droppings of dust.

All utensils designed for milk should first be scoured, then cleansed with soap, and rinsed with boiling water.

Bottles intended for milk should be cleansed coarse sand, baking soda and water; then rinsed and scalded.

Empty milk bottles should be properly cleansed; then filled with boiling water, and allowed to stand until used.

Chemical poisons which germs cast off, and various germs of contagion, are the contaminations in milk most dreaded.

Heat and cold are valuable preservatives when

applied to milk ; but extremes of either are injurious and destructive.

Heat is chiefly used to destroy the numerous germs which contaminate all milk, and which finally spoil it.

Cold is valuable because it retards the growth of germs, while applied to milk, but never any longer.

Milk should never be allowed to freeze, nor be subjected to more heat than necessary to sterilize it.

Milk is sterilized when it has been heated with steam or boiling water, long enough to destroy the germs in it.

Milk is pasteurized which has been heated at 167 degrees Fahrenheit for twenty minutes, and then cooled quickly.

Pasteurized milk is free from harmful germs, and has not been injured, as when completely sterilized or boiled.

Milk is best preserved when stored in small glass bottles, corked with cotton wool, and kept on ice.

When ice is not available, bottled milk should be immersed in cold water, which should be frequently changed.

When the separate feedings of milk are kept in small, closed bottles, the several portions are equally protected.

THE HYGIENE OF THE NURSERY.

Regular habits, proper food, and long hours of sleep are necessary conditions to a healthy infant.

The three prime essentials in the nursery are fresh air, good food and pure water.

Never put a bottle nipple into your mouth, and then into the baby's mouth ; this will often prove dangerous.

Always hold a baby in your arms when feeding it, in about the same position as if nursing it.

Feeding in the night, after the third month, is both inconvenient and unnecessary ; sleep at night is better than food.

Do not feed the baby because it cries ; this may be due to pain, and it is hurtful to fill an infant's stomach at such a time.

Have a rule for feeding the baby, and do not vary from it ; without regularity the mother becomes a slave.

More infants' lives are taken by over-feeding than by starvation. Never liken an infant's digestion or diet to your own.

An infant's thirst is not quenched by milk ; it needs clean water to drink with regularity.

Plain boiled water, given between feedings, will often aid the digestion, and satisfy the child when restless.

Vomiting or diarrhoea are indications that the child is either sick or approaching sickness, and probably needs a physician.

Cholera infantum would be of rare occurrence if proper attention was always given to the quality and quantity of the food.

A nursing mother who worries, or who is exhausted, or who indulges in excitement, may become a source of danger to her infant.

An infant is a creature of habit, and usually responds to the wish of the mother, if the mother has order in her will.

Rubber tubes, complicated nipples and nursing bottles are dangerous, and should never be used.

Light and loose clothing, frequent bathing or cool sponging, are necessities for the infant in hot weather.

Cleanliness, as applied to the body, the mouth, the food, the vessels, the clothing, the furniture, the floor, the carpets, the beds and the atmosphere, should be strictly observed.—Henry M. Coit, M.D., in *Arch. of Ped.*

UNCURED GONORRHOEA.

In February, 1892, I read before the Surgical Society a paper on Uncured Gonorrhœa. I propose to-night to still further discuss the subject with reference to its characteristics and management in the male. I referred then to the inutility of the "cut-off" in the matter of extension backward to the deep urethra of this disease, the frequency of such extension, its masked dangers to the infected, and its latent dangers to others. The glass test, that has been so frequently and full written up of late, shows the alarming frequency of the existence of active deep infection after all discharge from the urethra has ceased. For determining simply the existence or non-existence of posterior infection in reasonably recent cases, the simple collection of the patient's urine in two clean bottles will usually suffice. There will then be no shreds, but a general cloudiness of the water passed, in the first bottle only, if the disease be confined to the anterior urethra, in both if it has invaded the deeper parts. One must always take the precaution of adding a few drops of acetic acid to the urine to determine that the cloudiness is not due to phosphates.

In chronic cases, cases in which the urine may be cloudy or flaky, and that have a history, subjective, objective, and clinical, pointing to deep and obstinate involvement, an important question of differentiation presents itself. In a general way we may say that as many as five different localities may be singly responsible for the similar symptoms presenting in different cases, namely, the deep urethra, the bladder, the ureters, the renal pelvis, and the seminal vesicles. To exactly locate the disease in such cases is by no means a simple affair. It is indeed often an impossibility. More care must now be exercised in the glass test.

The patient should be seen with a full bladder, which, except in acute cystitis, is usually feasible. The anterior urethra, back six inches, should be carefully irrigated with some simple, cleansing hot wash by means of a fountain syringe hung seven feet from the floor, and a Jacque catheter, the patient standing. With a little practice this may be readily and effectively done. Two bottles are then used to receive the urine. The first represents the washings of the prostatic urethra, and therefore of the prostate and seminal vesicles, the second the washings of the bladder, and therefore of it, the ureters, and the pelvis. A floating or sinking *tripper fäden* or two, with otherwise clear urine, would indicate a granular deep urethra, and in the vast majority of cases endoscopic examination will confirm this, and furnish us the royal means of at once and effectually working a cure.

It is surprising what strong solutions of silver nitrate may be so applied without any other than the wished-for result. I rarely use in such treatment a solution weaker than twenty grains to the ounce, while sixty grains to the ounce is frequently required and well borne, a striking contrast with the objectionable effects so often following one or two-grain solutions of the same salt applied by means of a Keyes or Ultzmann syringe. I use exclusively in such cases the Otis-Klotz urethroscope, which is exceedingly simple of design and easy of application. By a simple trick the straight Klotz tube may be carried clear into the bladder. It should be passed gently as far as it will go, and then, with the thumb against the obturator to prevent its ejection, the flange should be steadily and firmly depressed between the patient's thighs until the distal end will be felt to pass through the cut-off. It should then be steadily pressed onward until the flange has packed the penis up against the symphysis pubis, and then the obturator withdrawn and the Otis lamp coupled on. The bladder being not wholly empty, a stylet armed with a bit of cotton should be used to remove the few drops of urine present, and the examination and subsequent application are but simple matters of detail. I have frequently by such procedure seen into the trigone. Proper care should be taken to limit the application to the deep granular parts. Silver nitrate is usually the agent used. Of late I have seen good results follow the use of Schering's argentamin.

If, as is however frequently the case, the entire volume of urine is cloudy, in the majority of cases the trouble is cystitis, the parts involved being the prostatic sinus and the trigonal region. Finger is the only authority with whom I am familiar who denies the existence of gonorrhœal cystitis. Ignoring here all discussion of all the good that follows the internal administration of anti-bleorrhagics and diluents, I desire to express my conviction that nothing will so speedily and so effectually cure

this condition as persistent daily bladder-washing. Of the agents relied on for accomplishing this end I may mention as best, saturated solutions of boric acid, potassium permanganate solutions, two to four grains to the pint, silver nitrate, one-half grain to the ounce, bichloride of mercury, 1 to 20,000 solution, and one-per-cent. trikresol. These are average strengths. The same method used in anterior urethral irrigation is used here, except that the catheter is carried into the bladder. Half a pint is injected and allowed to escape through the catheter, then, the second half-pint being introduced, the catheter is withdrawn and the patient allowed to void it naturally. Sometimes it is well to leave the second half, if mild, in the bladder for an hour or more.

The differential diagnosis between ureteritis and pyelitis is hardly possible. It should here, however, be borne in mind that those portions of the bladder, other than the trigonal region, are rarely, if ever, involved, and also that the location of the urethral orifices and the character of their epithelial lining both favor gonorrhœal extension. Unless speedily cured by internal medication it is probably only a question of time when gonorrhœal inflammation of the ureters will extend to the pelvis. Topical treatment of the ureters in the female has recently been successfully accomplished by Dr. Howard A. Kelly, and also in the male with the aid of the cystoscope by Dr. James Brown, of Baltimore, and Nitze and Casper, of Germany. This procedure, however, so far as the male urethra is concerned, can hardly be considered practicable for other than exploratory purposes. In the instances wherein it has so far been attempted, the object has been to determine the condition of the kidney to be left in a contemplated nephrectomy.

Many a sufferer from pyelitis has had his healthy bladder washed for months, and not a few have submitted to cystotomies for the cure by rest and drainage of a cystitis that did not exist. The modern revival of suprapubic cystotomy has much increased the frequency of this blunder due to faulty diagnosis. If it has accomplished no benefit for the patient, it has at least taught the surgeon a valuable lesson in diagnostic art.

There are several symptomatic features that are common to both pyelitis and seminal vesiculitis. Of these, two are prominent; first the obstinacy with which they persist after the most thorough topical treatment of prostate and bladder, and, second, their intermittent character, that is, their proneness to improve again and again to a point of apparent cure only to relapse in a day or two to their old state of pronounced pyuria. Fortunately these features eventually narrow down our diagnostic work to these two diseases, and equally is it a matter of gratulation that the differentiation is a comparatively easy task. Of course there are other conditions, such as tuberculosis, neoplas-

mata, stone in the bladder, senile ulcerative states, etc., that produce persistent pyuria. It is not of such, but rather of the clearly gonorrhœal deep troubles in the otherwise healthy subject that I am speaking.

Ordinarily the microscopic examination of bladder pus does not reveal much. When, however, we have concluded from persistent treatment and equal obstinacy on the part of the disease, from its intermittency, from rectal and, where possible, cystoscopic examination, that the disease is not in the bladder or prostate, the pus should be carefully examined, not with the expectation of finding tube casts, but with a view to the presence of the caudated and small oval epithelium that comes from the ureters and pelvis, a useful yet not altogether reliable guide in diagnosis.

To outline the final elements in the differentiation between pyelitis and seminal vesiculitis it is best to deal with the latter condition first. Each, it will be remembered, is characterized by obstinate resistance to bladder-washing and by intermittency of pyuria. Of the two pathological conditions, seminal vesiculitis alone has a pathognomonic symptom. The history of its occurrence, coincident with an absence of urethral disease, at once suggests the trouble. This is bloody semen. My first case of this sort was a classical one. He had resisted treatment for months, until finally the bloody mishap occurred as he was home coming on a New Orleans sleeper. He brought the bloody shirt to me. It was some eight years ago. I was at a loss to account for it. He went to Hammond, who amputated a liberal section of his scrotum for varicocele. I do not know his history since, I have had a few similar cases. Two recent ones are: P., a married man, with history of a cystitis not diagnosed specific six months ago. He came to me with the statement that, having used a condom at home to prevent conception, he had noticed that its contents were bloody. He had slight pyuria. I made a deep injection of silver, one grain to ounce, and ordered ergot. I have not seen him since. T., an unmarried traveling salesman, treated for acute and declining clap for two months, and intermittent pyuria for two months more, made two trips, each time coming home uncured. He came home the third time, March 20th, with the history of two bloody nocturnal emissions. This case serves me as an illustration of diagnostic methods. I ordered a free saline purge and then examined *per rectum*. It has been very wisely said, by Taylor I think, that the most erudite touch cannot discover the seminal vesicles when healthy. In this case I could feel above the prostate and on each side and beneath the urinary bladder two bodies, much like unfed leeches, soft, round, and an inch or two in length. Milking these after the methods suggested by Fuller, of New York, I produced a pyuria. One case more

in this connection. H., a patient well known to many of you, in that he has been operated on for cystic tumor seen by the cystoscope but found wanting after a cystotomy. A free purge and a rectal search disclosed two cord-like, not leech-like, because this is an old case, two cord-like bodies, plainly thickened, and enlarged seminal vesicles. So we may hope, where the question lies between pyelitis and seminal vesiculitis to include or exclude the latter by the history in some cases of bloody seminal discharges, and in most other cases by the presence after milking of pus in the urine.

The first case of pyelitis I ever saw to recognize was seen in consultation in Indiana some fifteen years ago, a septuagenarian, who, and this was considered the great feature of the case, had not tasted food in any form for twenty-one days. He had a fairly well-defined tumor over the right kidney. On three separate occasions in twenty-four hours I was able by manipulation to decrease the swelling and produce pronounced pyuria. Operative interference was denied, and he was gathered to his fathers. S., a young man of strumous habit, presented some eighteen months ago with a furious pyuria. History indefinite. After two months' bladder-washing, combined with cod-liver oil, diuretics, and tonics, the case was pronounced tuberculous kidney. He sought other treatment, and finally, *in extremis*, I learn submitted to a nephrotomy, a quart of pus being evacuated. He subsequently died. Another case, that of D., a young man with chronic cystitis (?), so diagnosed by me. He was treated for a couple of months topically and internally, with no benefit, and a perineal section done for rest and drainage, which was kept up with daily washings for one month. No benefit. Conclusion, faulty diagnosis, pyelitis, probably tubercular. He was sent to the country, and, while never particularly anæmic, he came home much improved, but still with pyuria. About two months ago he contracted a fresh gonorrhœa, which was speedily complicated with first single then double epididymitis. To-day he is relieved of these intercurrent troubles, but the pyuria goes on. He is a fairly robust man, a porter in a wholesale whisky house, and examination *per rectum* fails to show any enlargement of the vesicles.

How shall we diagnose either pyelitis or seminal vesiculitis other than by the methods I have so far laid down? Briefly, it can not always be surely done, but in many cases the following methods will prove of much value: In examining for vesiculitis order first a saline purge or an enema. Empty and wash out the bladder until the returning fluid is clear. Then throw into the bladder four or five ounces of a mild aseptic fluid. Leave it there and milk with the forefinger *per rectum* the vesicles. If you do not plainly feel them, crowd the forefinger deeply in above the

prostate and sweep downward over the base of the bladder where the vesicles should be. Let the patient rest a short while, and then void the injected fluid. If the fluid is cloudy, purulent, it is a case of vesiculitis. If not, while it may still be of that character, suspect more strongly the kidneys. Exclusion of the seminal vesicles, as I have indicated, goes a long way toward establishing the existence of pyelitis.

In the manipulative examination of pyelitis the procedure is practically the same. After washing the bladder and leaving four or five ounces of fluid in it, the patient should be made to lean over a chair or table and the dorsal and lumbar region should be stroked *a la massage* firmly and for some time in a direction from over the kidneys downward along the course of the ureters. While this is not so sure a means of milking as the rectal process for vesiculitis, it is sometimes of much value. If it fails the first time, at a subsequent trial half an hour or more should be allowed to lapse before the fluid is voided from the bladder—E. R. Palmer, M.D., in *Am. Pract. and News*:

MEDICAL NOTES.

Syphilis, Prof. Horwitz says, does not, as a rule, manifest itself for twenty-one days after incubation.

Pain is most severe in those cases of *pneumonia* which attack the lower lobe, according to Prof. Wilson.

If a case of *abdominal section* presents no bad symptoms, Prof. Montgomery says the dressing need not be disturbed for ten days.

Prof. Keen says that of all forms of *intestinal obstruction*, exclusive of hernia and congenital conditions, 30 per cent. are caused by invagination.

Prof. Parvin says that during the first few days after birth the *child loses weight*, but by the end of the first week it will have regained it again.

If a mother contract *syphilis* a short time before being delivered, she should not nurse her child, as the chances are that the child is not infected.

If the temperature rises to 105° or over, and remains there for any length of time in a case of *yellow fever*, Prof. Wilson says the prognosis is grave.

Prof. Keen says that mild forms of *goitre* are met with in women who are pregnant, and that with each successive pregnancy the goitre also enlarges.

In cases of *epilepsy*, Professor Hare says that females require a smaller dose of the bromides than males. This is true, both in adults and children.

Prof. Wilson says that we do not have a per-

sistent high temperature in *diphtheria*. If it should occur it is not due to the diphtheria, but to some complication.

Prof. Keen says that *abscesses* around the margin of the rectum usually originate from a suppurating pile, or from an inflammation of one of the anal mucous follicles.

The *puerpera*, Prof. Parvin says, should be directed to empty her bladder twelve hours after delivery, otherwise she may unconsciously allow the bladder to become over-distended and prevent spontaneous evacuation.

Prof. Keen says the *femoral hernias* become more frequently strangulated than any other variety, and that very often the first time they descend they become strangulated.

According to Prof. Parvin, the *meconium* is usually passed a few hours after birth; sometimes it is delayed for a few days; if longer, an enema of warm flaxseed tea should be given.

In cases of *shock*, Prof. Hare says that twenty drops of the tincture of digitalis should be given hypodermically, and repeated in an hour if the pulse does not show its influence.

Prof. Keen says that in *pyloric carcinoma* life can be greatly prolonged and suffering much relieved by dieting the patient and washing out the stomach as often as may become necessary from retention of food.

Prof. Parvin says that it disorders the digestion of a child to allow it to sleep with the nipple in its mouth, for the child taking a sip from time to time keeps its stomach in constant action.

In ileo-colic and colic varieties of *intussusception*, Prof. Keen says that very often the apex of the intussusception comes down as far as the rectum, where, by digital examination it can be felt.

If the mother *does not nurse* her child a few days after delivery, she should, according to Prof. Parvin, be given a saline purge, which he thinks tends to lessen the flow of blood to the mammary glands.

Prof. Keen says that small *gall-stones* retained in the intestinal canal become a nucleus for the formation of intestinal concretions, which increase in size gradually, and finally cause faecal obstruction.

Prof. Hare says the best treatment for *vomiting* occurring in remittent fever is the administering of small doses of morphine or three to five drops of spirits of chloroform in half a drachm of cherry laurel water.

Prof. Keen says when an operation for *obstruction* is performed, which has been due either to an adherent vermiform appendix or a diverticulum, these parts should be removed near their attachment to the intestines.

In cases of *fistula* after labor, Prof. Hare says a cure can sometimes be effected without an operation by touching the edges of the track of the fistula with nitric acid, thereby causing active granulation to be set up.—*Coll. and Clin. Rec.*

THE MANAGEMENT OF HÆMORRHAGE AFTER TONSIL OPERATIONS.

The frequency of alarmingly profuse hæmorrhage after tonsil operations, with an occasional fatal result, makes this a subject of exceeding interest to the surgeon. Such accidents should not, however, stand as obstacles in the way of performing these operations, for the necessity for operating is both frequent and urgent. Especially in children is the enlarged or hypertrophied tonsil very often met with, and the evil effects of the disease are so apparent to the medical and even non-medical observer, that it often calls for prompt action on the part of the physician. I do not intend here to enter into a discussion of the disease itself, but I would say that within the range of surgical diseases, I do not know of any affection that so often produces a train of more distressing symptoms than a typical case of enlarged tonsils; nor do I know of any operative procedure that gives more decided or permanent relief than their proper removal.

The ordinary hæmorrhage following the operation is of but small consequence, as, with a little patience and care, the blood soon ceases to flow of its own accord, or, if need be, a gargle of cold salt water suffices to arrest it in the course of a few minutes. But when there flows from the cut surfaces a steady stream of blood, continuing for hours, and when the frightened patient becomes each moment weaker and more nervous and more difficult to manage, then it is that the tact and nerve and skill of the surgeon display themselves to the greatest advantage. A typical case of violent hæmorrhage from an operated tonsil, uncontrolled by the ordinary remedies and means, is an experience that no doctor will willingly confront the second time. Fortunately these very severe hæmorrhages rarely occur, but they *do* occur, and the operator should be prepared to contend with them at any time. The operation is chiefly necessary in children from three or four to ten or twelve years of age, and with an experience of over 3,000 tonsil operations, I have seen but few cases of alarming hæmorrhage in children.

The inference, therefore, is that young children are not very liable to dangerous hæmorrhage—which, for obvious reasons, is a fortunate exemption. But it is in the adult that the great danger lies, because of the hardened tissues of the gland and the increased number and size of the blood-vessels over that of the child.

Generally, the tendency to serious hæmorrhage manifests itself immediately after the operation, or at latest after a few hours. In one of my cases, however, secondary hæmorrhage occurred five days after the operation.

There can be no objection to the trial of the various styptics, for they do in some instances arrest the flow, but they too often fail, and, even when successful, they leave behind most unpleasant results.

The actual cautery applied directly to the bleeding surface has been recommended, but the objections to its use are so obvious that I could not suggest it. But I can recommend compression as a remedy. Pressure applied directly to the wound is the most satisfactory of all means. Pass the forefinger; the end of which is covered with a piece of moistened sponge, or absorbent cotton, into the mouth, and carefully cover the cut surface, and with the wound between the forefinger of the one hand and the palm of the other hand placed externally, exercise a gentle but steady pressure. The hæmorrhage ceases immediately, but recurs upon the removal of the pressure. It is now a matter of courage and confidence on the part of the patient, and physical endurance on the part of the doctor. In most cases, pressure continued for ten minutes to one or two hours suffices to permanently arrest the hæmorrhage, but in rare instances it must be continued through twelve to twenty-four hours. In these last cases assistance must be called in, so that the persons exercising the pressure can be rested at intervals of half an hour. But I have never known this mode of checking the hæmorrhage to fail and I can confidently recommend it to any one having such a case.

I read a suggestion in some medical journal not long since, which I am inclined to think has some merit in it, though I have given it no trial; that is, the hypodermic injection of small doses of apomorphia, with the view of inducing nausea, which is supposed to exercise a beneficial effect in lessening the hæmorrhage. It is worthy of a trial, for I know by experience that extreme nausea bordering on fainting, or actual syncope itself, will arrest the hæmorrhage. Before learning to rely so implicitly upon pressure, I recall several cases, in which the nausea, on account of the loss of blood, fright and nervous shock, became so intense as to be in itself alarming. In three of these cases, after unsuccessfully trying every remedy at my command and when death seemed imminent, syncope followed (in one while lying in bed), and instantly the hæmorrhage ceased and did not recur upon reviving the patients.

But since I have learned what an infallible remedy the pressure is, I have had no such bad cases as just mentioned. If the pressure is properly done and continued long enough, a fatal result

cannot ensue.—A. W. Calhoun, M.D., in *Southern Med. Rec.*

A NEW METHOD FOR ANCHORING THE KIDNEY.
—Dr. Reed calls attention to the following anatomic landmarks in anchoring the kidney. Clinical experience teaches that movable and floating kidneys occur more frequently on the right side than on the left. In this connection it is well to remember that the right kidney, when in its normal position, is usually located a little lower than its fellow, and, on the average, measures about four inches in length. The left kidney is usually longer and narrower than the right kidney. The upper margin of the right kidney, when in its normal position, is on a level with the twelfth dorsal vertebra. This throws its margin slightly above the upper border of the twelfth rib, which is an important point to remember in the operation the author describes further on. The left kidney being located a little higher than the right, its upper margin not infrequently is on a level with the lower border of the eleventh rib, and sometimes even reaches a point slightly higher. The right kidney is usually about two and a half inches in width, while the left kidney seldom exceeds two inches, but makes up for its reduction in width by increase in length. They are each about one inch in thickness, which is also an important factor in considering the question of anchoring. By keeping these anatomic memoranda in view, the operator will be able to comprehend the mechanical conditions that are present, and which he must meet in anchoring a floating or movable kidney in its normal position.

Reed's operation consists in making the ordinary perpendicular abdominal incision over the median line of the kidney. As a rule, it need not exceed two and a half to three inches in length, depending largely on the thickness of the abdominal walls. Having made the incision sufficiently large to get the fingers in and bring the kidney to its normal place, he then uses a long needle, varying from five to seven inches in length. Two of these needles are threaded with aseptic silk-worm gut or aseptic silk, using but one ligature, armed with one of these long needles at each end. Having placed the kidney in its normal position (and in the case of a floating kidney having scarified the peritoneum so as to favor adhesions), he inserts his first needle through the upper and inner part of the cortical substance of the kidney, directly through the muscles of the back, coming out between the eleventh and twelfth ribs. The second needle, which is on the other end of the ligature, is also passed through in a similar manner, about an inch from its fellow, through the upper and outer cortical substance of the kidney. These ligatures are tied on the integument. If necessary, another suture is inserted through the

outer margin of the kidney, the first needle of the second suture being passed about an inch below the last needle of the first suture, and the second needle of the second suture about an inch below the first needle of the second suture, through the cortical substance of the outer portion of the kidney. By anchoring the kidney in this manner, the entire operation can be performed in not to exceed fifteen minutes, unless there are some troublesome complications to contend with. In tying the sutures, care should be taken to draw them sufficiently tight to not only hold the kidney in place, but to produce sufficient irritation to excite inflammatory adhesions, which are intended to hold the kidney in place, and which are essential to make the operation a permanent success. It is also necessary to be guarded against tying the sutures so tight as to cut through the peritoneum and the substance of the kidney. Either of these conditions, however, can be avoided by care on the part of the operator. After properly tying the sutures, the abdominal wound is closed in the ordinary manner. The anchor is allowed to remain from ten days or two weeks. At the end of this time adhesions are formed sufficiently wrong to hold the kidney in place when the anchor is removed, and in two weeks more the patient will be able to leave the hospital. The advantages claimed for this operation are simplicity, rapidity, and efficiency. The operation is practically bloodless. There is no danger of injuring the abdominal viscera. It is easily performed, and the results so far are certainly very satisfactory, as illustrated by the case with which the author concludes his paper.—*The Therapeutic Gazette.*

PRESENCE OF MIND.—If we were asked what single quality more than any other conduces to success in medical practice, we should be disposed to say presence of mind. The doctor must be master of himself, not only "though china fall," but though he discovers that he has been studying the pathological changes in a glass eye, or feeling his own pulse like the intoxicated physician of the legend. Swift, in his "Diary to Stella," speaks of the frequency with which people "reason wrongly at first thinking." Medical men are no more exempt from this infirmity than the rest of mankind; but the carefully-cultivated presence of mind, which is the first law of professional self-preservation, generally makes them more successful in concealing it. The young practitioner often gives himself away by offering the first muddy stirrings of his thoughts as an opinion instead of waiting for it to settle. Every one remembers the young doctor in one of Wendell Homes' books, who tells his first patient that he has discovered various complicated murmurs in his heart, which turn out to be the buzzing of a

fly in the stethoscope. An older hand might have heard the "murmurs"—perhaps with his ear at the wrong end of the stethoscope—but he certainly would not so artlessly have taken the patient into his confidence. We have known a "colored person" diagnosed offhand to be suffering from Addison's disease; and a dark spot, which subsequently proved to be amenable to simple treatment by soap and water, pronounced "at first thinking" to be melanotic sarcoma. Absurd mistakes are often due to nervousness rather than precipitancy. Students attending their first midwifery case, sometimes go astray in making the necessary examination. Shyness has made a young practitioner mistake an india-rubber bag for an ovarian cyst. Perhaps the most appalling misadventure of this kind befell the physician of the Emperor Rudolph the Second, who, in trying to feel his illustrious patient's pulse under the bed-clothes, grasped a different part of the Imperial anatomy, and was informed of his mistake by his Majesty in the following dignified words:—*Erras, amice, hoc est nostrum imperabile membrum*. How the doctor got out of his embarrassing position is not recorded, but presence of mind will often save an apparently hopeless situation. If a student who finds himself exploring the rectum instead of the vagina, will calmly rebuke the patient for not paying more attention to the condition of her bowels, he will change an imminent defeat into victory. Coolness will extricate a man from almost any difficulty. We have heard a story of a distinguished surgeon who began to amputate the body from a limb, and when his attention was called to the fact, carried it off by telling the assistant to take his hand out of the way. Danton's maxim *De l'audace* finds its application in medical practice under such circumstances. The possession of this quality is the secret of success of many second-rate men, and the lack of it accounts for the failure of many otherwise admirably equipped.—*British Med. Journal*.

PROFESSOR BROUARDEL ON THE MEDICAL PROFESSION.—One of the great questions of the day undoubtedly is, What shall we do with our sons? In the profession with which we are more immediately concerned there are at the present moment close on 33,000 gentlemen with British qualifications practising the science and art of medicine in all parts of the world, but chiefly within the narrow limits of our own small islands. The plethora of *alumni* in our schools is truly alarming, and yet we have cause to congratulate ourselves that matters in this respect are not so bad with us as they are elsewhere. In the United States, for instance, the medical student roster last year was said to contain no fewer than 38,850 names; being an augmentation of more than 5500 since 1892. In France the overcrowding of the

medical schools is also excessive, but in this connection we cannot do better than quote the remarks delivered by Professor Brouardel at a recent meeting of the Association des Médecins du Département de la Seine: "Two years ago I drew your attention to the fact that the number of medical students was increasing rapidly. The augmentation still continues unabated. In all the French faculties our future *confrères* are now twice as numerous as they were ten years ago. The same kind of thing is going on in Germany and likewise in England. Various causes have been invoked in explanation of this state of affairs; many people thought that the law regulating military service was to blame in the matter. There is no reason whatever for this supposition. The laws have not been altered in Germany or in England, and yet the rate of progression remains the same. In France the female midwifery candidates, who have nothing to do with military service, have doubled their numbers in the last five years. For my part I am convinced that it is the publicity accorded to the achievements of science which is responsible for the illusory ideas entertained by heads of families. Day by day in their newspapers they see the great importance that on all sides is attached to public health, civil and military, and logically enough imagine that the persons charged with the solution of the great problems involved receive a proportionate compensation. They conclude that their offspring will derive both honor and profit while pursuing this grand career. They would be much astonished if anyone were to point out how the efforts we make to render houses wholesome, to root out epidemics, to improve medical charities, all have the effect of narrowing more and more the field wherein the medical man was formerly wont to garner a meagre harvest. Now, in ten years' time the number of reapers will have doubled. I do not want to forecast the consequences from the point of view of medical practice, but there is one thing of which we may be perfectly sure: if the number of medical men has doubled, the number of unsuccessful practitioners will have increased threefold." The eminent French sanitarian doubtless correctly estimates the motives that induce his fellow countrymen to enter their sons in medicine. All communities are alike and, although many-headed, are not endowed with a corresponding amount of intelligence. And yet it is difficult to conceive how any reasoning being can suppose that the average medical man's life is either an easy or a lucrative one. There is no other profession or calling in which the hours are so long. A busy practitioner (and if he has to live by his labor he is compelled to be busy) must remain on duty twenty-four hours out of the twenty-four. At no period of the day does the happy moment arrive when he can put his business on one side

and say, "Now I may enjoy myself." Professor Brouardel's remarks regarding the way medical men cut the ground from under their own feet, as it were, by their persistent endeavors to improve the sanitary condition and general health of the community are very pertinent and should be widely disseminated. In no other walk of life do we hear of men who, as a matter of course and without the smallest fuss, are ready and willing to act in a manner that is diametrically opposed to their pecuniary interests.—*Lancet*.

THE USE OF COCAINE TO PREVENT RESPIRATORY DISTURBANCES DURING CHLOROFORMIZATION.—It is quite possible that others have been struck by the ease with which a patient whose tonsils and post-nasum have been penciled with a solution of cocaine previous to the use of chloroform takes the anæsthetic. For some time I have practised this use of cocaine for tonsillotomy and removal of adenoids after having noticed the comparative freedom from hæmorrhage in a case where I attempted, but without success, to operate under cocaine alone, and had to give a general anæsthetic. In this case the tonsils were removed with very little hæmorrhage indeed, and I was able at once to remove the adenoids unhampered by hæmorrhage from the tonsillar stumps. Apart altogether from the fact that cocaine thus used eases the subsequent use of chloroform (or ether), this circumstance of the freedom from hæmorrhage in an operation (tonsillotomy), where such is always dreaded, ought to be freely observed. Before the action of the cocaine is over the patient is already conscious, and ice can be employed to prolong its effect. I should say that the cocaine, which need only be applied in weak solutions (two per cent.), reduces the loss of blood in the double operation of removal of tonsils and adenoids by over fifty per cent.

Rosenberg, of Berlin, has recently drawn attention to the fact that if the mucous membranes of the upper air-passages are anæsthetized by cocaine before the administration of chloroform, the disturbances consequent upon their irritation are obviated. This author has found by experiments that at the beginning of anæsthesia if the blood pressure be considered as equal to 100, the systole is represented by 210, and the diastole by 40. Under normal conditions, on the contrary, the blood pressure being the same, the systole is represented by 110, and the diastole by 90. These modifications are due to respiratory disturbances consequent upon irritation by the chloroform of the mucous membranes of the upper air-passages. In two or three cases of my own where this combination of general and local anæsthesia has been employed, less chloroform has apparently been used, and the patient went under with less struggling and fright, and more quickly. In strabis-

mus operations cocaine furnished a field free from hæmorrhage, but as it abolishes sensation in the conjunctivita, it might prove embarrassing to the chloroformist.—William Robertson, M.D., in *Brit. Med. Jour.*

A NOTE ON A SIMPLE MANNER OF OVERCOMING THE CATARRH CONSEQUENT ON THE ADMINISTRATION OF POTASSIUM IODIDE.—I have often observed that patients taking iodide of potassium suffered in a marked degree from "iodism," the chief symptoms being coryza with a sometimes profuse discharge, sneezing, pains over the frontal sinuses, swelling of any part of the mucous membrane of the mouth, and a sense of heat in the chest. The foregoing phenomena are identical with those attendant upon the inhalation of free iodine (Mitchell Bruce), and it has been observed that one is more likely to be attacked with catarrh if the iodide of potassium contains free iodine as an impurity. This seems to justify the belief that the catarrh of iodism is due either to iodine being secreted by the salivary glands, or to the circumstance that iodide of potassium is broken up in the mouth after its secretion and free iodine liberated. The latter view is supported by Schmeideburg, who has proved that iodide of potassium in the presence of carbonic acid is decomposed, the latter being abundant in the expired air in the region of the salivary glands. Whilst taking charge of Dr. Herschell's out-patients at the National Hospital for Diseases of the Heart, I have been able to stop the catarrh in three well-marked cases by adding to the mixture (being in each case ten grains of iodide of potassium and half an ounce of water) five minims per dose of tincture of belladonna, my object being to reduce the salivary secretion, and in each case the result was satisfactory. Any antisialagogue would doubtless have a similar effect, but belladonna is, in my opinion, the most useful, as it can easily be given in the form of a mixture with the iodide, and in the small dose that is used in such cases, it counterbalances the so called "depressant" action of the potassium.—George Cohen, M.B., *Lancet*.

OPEN-AIR TREATMENT OF WHOOPING-COUGH.—Ullmann, after pointing out the failure of all suggested "specifics" for whooping-cough, and the little effect which drugs of any kind have on the frequency or the severity of the paroxysms of cough or the duration of the disease, proceeds to urge (*Jahrb. f. Kinderheilkde*, Bd. xl. H. i., S. 39) the value of open air (*freiluftcur*). He relies chiefly on the consideration that under ordinary circumstances the patients have fewer paroxysms during the hours in which they are out of doors. To establish this he quotes records of the paroxysms in certain cases. Thus, in one case, while indoors, the child (aged 18 months) had a paroxysm on an

average every 48 minutes, while out of doors it had one every 91 minutes. In another severe case the child had nearly three times (2.74 : 1) as many paroxysms indoors as out of doors. In a mild case the difference was less (1.4 : 1). The difference in all the cases varied on different days, but it was on the whole sufficiently marked to strike and convert the parents, at first disposed to distrust the advice given. He states that a threatening paroxysm may be arrested sometimes when in the house by carrying the child to an open window, where it takes several deep inspirations, and the feeling of distress and anxiety which precedes the paroxysm passes off. Ullmann recommends that in summer and on fine days in winter the patients should be kept out of doors—not for a few hours only, but from morning to evening. He attaches much importance to their being given their meals out of doors. The paroxysm of cough and vomiting which so commonly follow a meal is thus in many instances avoided, and the serious deterioration of general nutrition liable thus to be produced is prevented. He does not look on bronchitis or even broncho-pneumonia as a contra-indication of the open-air cure.—*Brit. Med. Jour.*

SELF-POISONING BY CHLOROFORM.—Few practices are at once more pernicious and more common than auto-intoxication by means of chloroform. Within a few days two persons have done themselves to death by inhaling chloroform. Mr. F. C. Banks, as a result of a poisoned wound inflicted by pricking his finger with a toothpick, suffered great pain. It appears from the evidence of his wife that he inhaled chloroform to obtain relief. It is almost incredible that this man had for eighteen months received regularly daily at his house two ounces of chloroform for auto-intoxication. He poured a small quantity upon a paper cone and inhaled it. The wife awakened to find unfortunate man comatose and stertorous, and from this state he never recovered. It seems to us perfectly monstrous that the victim should ever have had the chloroform supplied to him. The laity know so little of the perils of inhaling anaesthetics that they ought to be protected from themselves and others equally incompetent to administer the drug. In the second case, a young surgeon, Mr. T. G. Sloan, of West Calder, suffering from neuralgia and sciatica, inhaled chloroform to secure sleep and forgetfulness of his pains. While comatose he appears to have fallen forward and so inhaled a lethal dose and died. Thus two lives are sacrificed to a reckless use of one of the most beneficent drugs given to man to assuage those ills to which flesh is heir.—*Lancet.*

A CASE OF SULFONAL POISONING IN A DIP-SOMANIAC.—A married woman, aged thirty-seven, separated from her husband owing to

her habits of intemperance, had been abstemious under moral restraint for about three months, when, on May 24th, 1895, she showed signs of an approaching attack of alcoholism. She was watched carefully for a time, but owing to illness and removal of her attendant she was left in charge of a maid. Her first dose, on June 1st, was about one pint and a half of methylated spirit, partly procured from a lamp in the house; then two-pennyworth of the same was obtained from a lamp shop (about six ounces), the druggists in the district having received notice not to serve her; thereupon, her thirst seemed to be so extreme that she resorted to some painters, from whose can of turpentine she took a drink. She next discovered a bottle containing 100 tabloids of sulphonal, containing five grains in each, which had previously been taken from her; and which she had received by post; these she chewed up in her mouth one after another till she had swallowed fifty-three (equal to 265 gr.) About 5 p.m. the same day she was found by the maid (who had unfortunately been obliged, owing to domestic duties, to leave her a great deal to herself) in a state of stupor on the floor, and was carried to bed. At 11.15 p.m. I was summoned to her and found her sleeping on her side with her knees drawn up and the pupils slightly contracted and insensible to light. When roused she smiled graciously and lapsed off to sleep again; she tried once to raise herself in bed, when she fell powerlessly back again. Next day the legs were found to be extended, and the soles of the feet were arched in a state of extreme flexion. The bowels were confined. She slept from 5 p.m. on June 1st till 5 a.m. on the 4th—sixty hours—and did not regain speech till the 7th and the power of locomotion till the 8th. This case is interesting as showing the irritation produced to the plantar branches of the post-tibial nerve—presumably by the sulphonal—and the long period that elapsed before the toxic flexion of the soles made itself manifest, thus showing the slowness of the action of the drug.—*The Lancet.*

FRACTURE OF THE FEMUR FROM MUSCULAR ACTION.—Dr. Irving S. Haynes reported the case of J. W., an athlete, thirty-six years of age, who, while bowling, had attempted to throw a heavy ball, in doing so had lost his equilibrium, and, in endeavoring to regain it, had brought such a strain upon the left femur as to fracture it in the middle. The line of the fracture had extended slightly obliquely from above and inward, downward and outward. He had been in unusually robust health, and had been free from any specific disease: hence the manner in which the fracture had been produced was of unusual interest.

Dr. J. W. S. Gouley recalled the case of a healthy young man, under thirty years of age,

who, while endeavoring to hurl a ten-pound dumb-bell to a considerable distance, had thrown back his right arm so far that it was beyond the control of certain muscles, with the result that the humerus had snapped just below the deltoid insertion. Of course, in this case the weight of the dumb-bell had been a decided factor in addition to the muscular action. The fracture had united satisfactorily. No disease of the bone had been found, although the speaker said that when fracture occurred in this way he was usually suspicious of the existence of malignant disease of the bone. It was not uncommon for fractures of bone to occur from very slight causes, such as movements in bed, where there was malignant disease of the bone.—*N. Y. Med. Jour.*

A NEW SIGN OF DEATH FROM EXPOSURE TO COLD.—In the *Wiener medizinische Blätter* for July 11th, there is an abstract of an article published in the *Journal für öffentlicher Hygiene, gerichtlicher und praktischer Medizin* for March, by Dr. S. Wischnewski, who has made post-mortem examinations of forty-four frozen persons. In forty instances he found hæmorrhages on the mucous membrane of the stomach. These hæmorrhages looked like little spots somewhat raised above the surface of the mucous membrane. They were round or oval in shape, of a dusky or blackish color, and reached the size of a pea. They varied in number from five to a hundred in individual cases. In cases where the person had died from some other cause, and then the body had been frozen, the author did not find these hæmorrhages. The appearance of the hæmorrhages was not affected by the condition of the stomach in regard to being full or empty. By way of test experiments the author froze rats and guinea-pigs, and found the same hæmorrhages as in man, but in cats and young dogs frozen to death he did not observe them, but only a general hyperæmia of the gastric mucous membrane. The author considers this sign of medico-legal importance, as significant of death from exposure to cold.

REMOVAL OF A PIECE OF PYLORIC MUCOUS MEMBRANE BY THE STOMACH-TUBE.—Ebstein (*Berliner klin. Wochenschrift*, 1895, No. 4) reports a case in which this accident happened, the fragment being found in the fenestrum of the tube. The case was one of chronic peritonitis with strictures and dilatations of the duodenum. Death occurred from septic peritonitis four days after a laparotomy. Neither loss of tissue nor cicatrix could be found in the stomach. Ebstein thinks this accident much more frequent than is usually believed. Position and size of the stomach, and, as in the case reported, adhesion with neighboring organs, favor the occurrence. The author advises distention before passing the sound in

order to be able to form an idea of the extent and configuration of the stomach. The sound must be sufficiently thin; must not be removed too rapidly, but slowly, and while water is allowed to run in. The occurrence of vomiting while the tube is in the stomach necessitates special caution.—*Am. Jour. Med. Sci.*

RULES AS TO TIME OF RUPTURING THE AMNIOTIC SAC IN LABOR.—1. In multipara, rupture when os is fully dilated.

2. In primipara, delay until the small parts are also dilated.

3. In cases of face and breech presentation, delay in rupturing the sac is best.

4. Where the pelvis is small, and the fœtus large, delay rupturing.

5. In premature labor, with dead fœtus, rupture early.

6. Rupture the sac early when the membranes are unusually thick, tough and unyielding.

7. When speedy delivery is demanded, rupture early and dilate with the fingers.

8. Rupture the sac when an excessive amount of amniotic fluid retards labor.

9. When version is necessary, and can be accomplished by bimanual manipulation, perform this operation before rupturing.

10. Remember that a dry labor is always to be deprecated, hence do not rupture at all, unless for good reasons, and the case demands it.—*Times and Reg.*

MERCURY IN MENINGITIS.—Mercury is an agent of unrivalled excellence, judiciously administered; in inflammatory conditions of the fibro-serous membranes. On the meninges, it acts with especial energy; therefore, why, in those cases of cranial trauma, a purgative dose of calomel is given early, and repeated later, should symptoms of meningeal trouble threaten; the dose of the drug being so apportioned as to promptly secure its full therapeutic effect, without its possible lethal action.

ABSORPTION BY THE RECTUM.—Posner (*Ber. über die Verh. des 13 Congress für innere Med.*) has made some observations showing the rapidity of absorption of certain substances by the rectum. Certain solutions, like indigo-carmin, methylene-blue, etc., injected into the rectum appear within fifteen minutes in the bile and urine. Other substances, such as naphthol green B, were not absorbed at all. The experiments confirm early observations as to the importance of the rectum in absorbing remedies or poisons, and led von Noorden to recommend anew the use of quinine suppositories in whooping cough.—*Am. Jour. Med. Sci.*

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TORONTO, SEPTEMBER, 1895.

Editorial.

SEASONABLE SKIN DISEASES.

At this season of the year one is rather more than usually apt to be faced in practice with acute skin-lesions, and not the least frequently occurring just now is that of the Exudations, of which nettle-rash is a typical member. Of course the inflammations come under this large class, whatever may be their cause, heat, bites and stings of insects, the use of fresh or green fruit, or other new and unusual additions to the year's dietary which this season brings, or the gastric and intestinal disturbances peculiar to the season of the fiery Sirius.

Disorders of secretion and of excretion are not so common, except in so far as they affect the sweat glands, hyperidrosis and chromidrosis and the accompanying intertrigo, being frequently seen. The hæmorrhages, the hypertrophies, the atrophies, the tumors, the neuroses, the parasitic affections, are all more apt to pursue the even tenor of their way uninfluenced by the season. Some of the atrophies, such as vitiligo, are, of course, more apt to be a cause of trouble, from the tanning of the hands and face, which so accentuates the unpigmented area, and brings it into evidence against the unguarded practitioner (in the writer's experience always a homœopath) who, in the late autumn promised a positive cure when the patient was driven to him for cosmetic reasons after her summer in the garden, and found that

in the darker season of winter the patches faded, only to be as sharply contrasted as ever when the sun got at them in the spring again.

A disease somewhat in fashion a few weeks ago, especially among boys and young men "of the baser sort," was a peculiar exudation, in gross appearance very erysipelatous, but not advancing by the finger-like projections along the lymphatic areas of the skin seen in the latter affection, but with even border, raised, red, and œdematous, like erysipelas, but without the burning and tensive pain. Constitutional disturbance was absent, but patients and friends were alarmed at the gradual disfigurement of feature, closing up of eyes, distortion of the nose and mouth, produced by the œdema. Two cases of this the writer saw, about the same time, in June, and each was attributable, without any doubt, to the same cause. The patients, though living in widely different parts of the city, and not acquainted with each other, belonged to the army of boys who spend the most of the day, when the swimming season opens, in the green waters of the Don, and where the sun could get at the skin, especially where the hair could constantly, by its dripping, keep the skin alternately moist and dry, some of the infective bacteria of the filthy water had evidently found a suitable nidus, and set up an œdema of the skin, not accompanied by severe inflammation, and marked by no constitutional disturbance. It was a form of *Dermatitis venenata*, not due to poison ivy, not erysipelas, and not sunburn.

Several cases of urticaria have lately been brought under the writer's notice, due mainly to the ordinary cause, absorption from the intestinal canal. As to etiology, the authorities seem agreed that this is the first cause in the order of frequency, and that nervous depression or worry, comes next, then disease of the pelvic viscera, the latter being as frequently as any other, perhaps, the cause of chronic urticaria. The management of these cases, the cause being once intelligently determined, is theoretically simple enough. If digestive disturbance co-exist, give purgatives, and in very acute even cases an emetic is of much service, if the ingestion of the irritant be very recent. The empirical reputation of alkalines and salines in such diseases is probably due to a neutralizing influence upon the toxins in the alimentary canal, if not actually upon those already in the blood, and they

seem to be of distinct value. If the writer were to be shut down to the use of one drug in this affection, it would undoubtedly be antipyrine, in 5 to 10 grain doses every four or six hours. Its action upon the violently itching and frequently recurring local lesion is often very marked, and is probably due to its effect upon the vasomotor nerves of the skin, upon disturbance of which the exudation into the corium depends. Other sedatives such as the bromides, gelsemium, bismuth, belladonna, ether, chloral, chloroform, have all been recommended, and in some cases found useful. Lassar speaks highly of sodium salicylate in 20 or 25 grain doses every two hours.

Local treatment, even if it were placebo, cannot be neglected. It is of distinct advantage however; cold water, carbolic acid lotion, one part in 20 to 60 of cold water, lotions either strongly acid, as lemon juice or vinegar and water, or strongly alkaline, are often very grateful to the patient. Sometimes ointments are better, as of camphor and chloral, with carbolic acid, ungt. aq. ros., or ceratum galeni, the ordinary benzoated oxide of zinc ointment, or 20 grains of acetanilide to the ounce of vaseline or any other ordinary excipient. Other local applications are menthol, cocaine, naphthol, belladonna, or ichthyol ointment.

The "diathesis" of the patient must be thoroughly investigated, especially if the disease is inclined to be chronic, and gout, rheumatism, or malaria if possible driven from the field. Cases benefited by quinine are probably malarial in origin. Dietetic errors, if habitual, must be pointed out and corrected. The writer cannot refrain from mentioning, before closing, a case of urticaria of the respiratory mucosa recently seen by him. A baker working in an underground bake-shop, which was lighted by gas, and probably as unhygienic as most such places are, had on three occasions been seized suddenly by a sense of itching and tightness in the respiratory passages, which lasted two or three hours and gradually passed off. On the first two occasions he consulted a physician in the city, who told him that it was due to gas poisoning, although the patient had told him that he had noticed that the attacks came each time after he had eaten some old cheese. Even this "tip" did not prevent the physician withdrawing blood from the patient, submitting it to microscopic examination, and gravely declaring

that he found evidence in it of poisoning by gas; a curious instance of the possible vagaries of the human mind.

SOME CLINICAL POINTS IN DIPHTHERIA.

Diphtheria, a disease ever of great interest to the medical profession, but more so of late since the introduction of antitoxine, possesses some interesting clinical points which have not received due consideration in text books dealing with this subject.

The temperature in diphtheria is generally reported to possess nothing very characteristic and to depend entirely on the local condition, the extent and situation of the surface involved, and the character of the infection, whether simple or mixed.

This we believe to be true in so far as it goes, but on examining a number of charts of cases of all degrees of severity, we have found in a large proportion of them (about sixty-five per cent.) a secondary rise of temperature, occurring at about the end of the first week of the disease.

The patients were generally admitted to the hospital on or about the second or third day of the disease, with temperature varying from 99° to 104°, the average being about 101°. During the first three or four days subsequent to admission the temperature gradually fell to normal or nearly so, providing no complication existed to disturb the natural course of events, and then after remaining stationary for from twenty-four to thirty-six or forty-eight hours, rose suddenly to a point varying from 100° to 103°, falling to normal again in from one to three days. A peculiar feature noticed in connection with this secondary rise was, that of four patients whose temperatures reached 102° or over, three died from "heart-failure."

No constant relation appeared to exist between the height of the primary and secondary fevers. So far as could be discovered, no special local or general condition was constantly present during this rise. In some the throat was clean, so far as could be seen, in others membrane was still present; the cervical glands were sometimes much enlarged, in others they were small; constipation occasionally existed, but more frequently the bowels were in good condition; and the patients, as a rule, beyond some malaise with slight anorexia, seemed but little affected by the recurrence of the fever.

If it is a fact that in diphtheria there is a characteristic secondary rise of temperature in a large percentage of the cases about the end of the first week of the disease, it will prove helpful in those cases of angina in which one is unable definitely to say that diphtheria does or does not exist, and when a bacteriological examination of the discharges cannot be obtained.

As mentioned above three out of the four cases whose secondary fever was high, died of "heart failure."

Just a word on the premonitory symptoms of that most terrible of all complications of this deadly disease.

In many cases death is so sudden as to preclude the possibility of premonitions, or supervenes so rapidly after their appearance that no time is given for action; but, in a very large proportion of the cases, there are distinct premonitory signs, which give us sufficient warning and time to endeavor to afford relief and to call the friends and prepare them for the almost inevitable sad result.

The combination of events to which we wish to direct attention is *an acute pain in the epigastric region combined with vomiting* and a feeble pulse. So general is this combination, that the nurses in charge of diphtheria wards have learned to regard such cases as almost necessarily fatal.

Of several cases we have observed in which these signs presented themselves, only two recovered, and one of these was confined to bed for some weeks, owing to the weak condition of the heart, while the other's trouble was explained by the existence of obstinate constipation, and disappeared on the successful exhibition of a purgative.

The time at which the fatal result ensued, varied. The shortest was about half an hour; the longest several weeks; the average from three to twelve hours after the warning.

With regard to treatment there is little to add to what is usually found in text-books and adopted.

The liability of stimulants given by the mouth to provoke the continuance of vomiting, renders it an undesirable method of administration.

If retained by the bowel give your alcohol *per rectum*, or if not, along with the strychnia, digitalis, etc., hypodermically.

Nourishment in the form of raw eggs and pep-

tonized milk *per rectum*, or by the mouth, if tolerated, should be given in small quantities, frequently repeated. Mustard poultices to the epigastrium do much to relieve pain, while a smart purge removed the symptoms entirely in one case and seemed to afford some relief in others.

A patient having once presented these symptoms during an attack of diphtheria, should be most rigidly kept in the horizontal position for a much longer time than would otherwise be done, and by the administration of tonics, etc., and the exercise of due caution for some time after rising; the danger reduced to a minimum.

"AN OVERCROWDED PROFESSION."

There can be no doubt that the profession of medicine has become terribly overcrowded in Ontario, notwithstanding the raising of the standard of matriculation by the Col. of Phys. and Surg. Each successive effort made to discourage candidates for the magic M.D., succeeding only in filling the halls of the Medical Colleges with an increased number of school teachers and farmers' sons, who imagine that the profession must have a "good thing" that they are trying to keep others away from.

Viewed from every standpoint the future of medicine as a means of making a living is a black one indeed, and there can be no doubt that every man enters medicine with that end in view, apart from any view of a philanthropic nature, for every man must live, and in a new country such as ours, there are very few who have had the good luck to have a large enough fortune to enable them to use medicine as a means to an end in furthering scientific research.

In former days, in Canada at least, the doctor had a very much higher standing in the community than at the present time when education is so cheap and so common that the professional ranks are filled with men who have no real qualifications for this calling other than the parchment containing their easily won degree.

The proportion of medical men to the population at large in Ontario, is about 1 to 600, and steadily getting worse. In Toronto it is even greater, so then any one can see that there would not be a living if practice was equally divided among the practitioners, and we know that some of them have quite large incomes, though they are

few, the great majority barely paying their running expenses, and many not even that.

Each year sanitary science is making greater strides, lessening the number of epidemics, and thereby the medical incomes. Lodge practice is sapping the vitality and the self-respect of the men who are forced by circumstances, "as they say," to engage in it. The oculists have keen competitors from opticians styling themselves "Doctors of Refraction." Instrument makers fit trusses and splints of all kinds, and the Council seems without the power to prevent in any way the practice of medicine, for such it is, by these men, who frequently make fortunes or a splendid living when the unfortunate M.D. struggles along with a bare existence.

The principle reason of this overcrowding is the idea, so common among the laity, that medicine offers a safe and easy means of making a fortune. On every hand one meets with people who say, "Oh, you doctors make lots of money," and really believe that such is the case. The country school teacher sees the local doctor flying around at all times, driving here and there, wearing out his life for scant remuneration, imagines he must be making lots of money, and starts off with great hopes, and a few hundred dollars, to the nearest college and becomes one more victim to misplaced ambition. The writer met recently, a dentist with an income of \$4,000 a year from his practice, who proposed to go into medicine, alleging that as a dental surgeon his social position was not good enough. I informed him that the presence of an M.D., would be of little avail in Toronto, that other qualifications were necessary, and that doctors did not become society men, unless they possessed leisure, wealth, and connection, as is the case with all other professional or business men.

It is difficult to indicate any remedy for this over-crowding, except by a gradual education of the public to the fact that the profession of medicine contains more starving or semi-starving members than almost any calling whatsoever, and we witness the spectacle, which will be common enough before many years have passed, of hundreds of possessors of medical degrees forced into merchantile or agricultural pursuits in order to make a living.

ASYLUM DISTRICTS.

From the frequent inquiries addressed to the superintendents of the several asylums by medical practitioners in the province who are interested in having patients admitted, it would appear that the recent changes made in the districts allotted to the respective asylums are not generally known by the profession. Often delay and annoyance has resulted to medical men in consequence of the new arrangement of the districts. We have been requested by the Inspector of Asylums to draw special attention to this new arrangement, and in the hope of benefiting those who may have occasion to send patients to the asylum, we quote from his last report the following allotment of the districts which are now attached to each asylum:—

No. 1.—London District, to embrace the counties of Essex, Kent, Elgin, Lambton, Middlesex, Oxford, Huron, Bruce and Perth, these having a combined population of 540,839, for which there is provision in the District Asylum for 1 patient to every 537 inhabitants.

No. 2.—Hamilton District, to embrace the counties of Halton, Wentworth, Lincoln, Haldimand, Norfolk, Brant, Wellington, Waterloo, Dufferin and Grey, having an aggregate population of 454,043, for which there is accommodation in the District Asylum for 1 patient to every 493 of the population.

No. 3.—Mimico District Asylum, to embrace the counties of Peel, Simcoe, Ontario, Victoria, Peterborough, and the Districts of Muskoka, Parry Sound, Nipissing, Algoma, Thunder Bay and Rainy River, having an aggregate population of 318,728, for which there is accommodation in the District Asylum for 1 patient to every 569 of the inhabitants.

No. 4.—Toronto District, to embrace the city of Toronto and county of York, having an aggregate population of 245,101, for which there is accommodation in the District Institution for 1 patient to every 518 of the inhabitants.

No. 5.—Kingston Asylum District, to embrace the counties of Durham, Northumberland, Hastings, Lennox, Addington, Prince Edward, Frontenac and Renfrew, having an aggregate population of 267,170, for which there is accommodation in the District Institution for 1 patient to every 477 of the inhabitants.

No. 6.—Brockville Asylum District, to embrace the counties of Leeds, Grenville, Dundas, Stormont, Glengarry, Prescott, Russell, Carleton and Lanark, having an aggregate population of 288,440, for which there is accommodation in the District Asylum for 1 patient to every 487 of the inhabitants.

The territorial district allotted as No. 4, or Toronto, may appear at first sight to be comparatively small, but it must be borne in mind that, in the higher pay wards, there is accommodation for 230 patients, which leaves only 478 beds available for warrant cases. The higher pay wards are available for patients from all sections of the province, and are not limited to any territorial division, from which they may be admitted.

ABSCESS OF LUNG TREATED BY DRAINAGE AND IODOFORM; RECOVERY.—J. Eustace Webb, M.B., *Aberd., Lancet*, June 29, 1895, gives the following important contribution to our literature on the surgery of the lung.

A woman aged twenty-seven years came under the care of my partner, Mr. Wm. Hammond, and myself on Aug. 1st, 1894. She had given up all hope of recovery, as she had been told by two medical men that she could not live many weeks. Her mother died of lung disease at the age of thirty-two, and on the maternal side there was a decided history of phthisis. Her father was aged fifty-eight; he suffered from rheumatic gout. She had no brothers or sisters. She had inflammation of the lungs in early childhood, since which time she had been perfectly well. In the latter part of June, 1894, she was suddenly attacked, at the time of her menstrual period, with pain in the right side of the chest, which was followed by cough and expectoration. When examined on Aug. 1st, the right chest gave the following physical signs: Great dulness, extending all over the base of the lung posteriorly to a line well above the angle of the scapula, and at the side and anterior part of the chest below a line continued horizontally round from the ensiform cartilage; vocal resonance and fremitus were present, but not markedly increased; the breath sounds were distant, but heard to the extreme base. The tape at the level of the ensiform cartilage showed an increase of one inch on the right side. The breath

was fetid, had the characteristic odour of pus, and the air of the whole cottage was pervaded with the same sickly odour. The expectoration was purulent and nummular. The body was fairly well nourished, but she stated that she was losing flesh rapidly. Her pulse was 120, her temperature 102° F., and her respiration 30. Her appetite was very bad, and the tongue was red and glazed. As she lived six miles from my house a record of her temperature, etc., could only be taken once daily. On Aug. 9th the chest was aspirated in the axillary line in the sixth intercostal space; the needle penetrated to a depth of two and a half inches, and twelve ounces of pus, slightly mixed with froth, were drawn off. For some days after the operation she appeared greatly relieved, the fetor of the breath was very much diminished, and she was able to relish her food. No marked improvement, however, was noted in her pulse, temperature, or respiration; the breath sounds could be heard more distinctly at the base, but there was no appreciable diminution in the dulness. On Aug. 25th she vomited about half a pint of pus, and again the fetor of the breath became less. The physical signs suggesting an increased collection of pus then became more marked, the dulness extending to above the middle of the scapula behind and to a corresponding level in the side and anterior part of the chest. She was losing flesh rapidly. Her respiration was 40, the pulse was 120 and very soft, and she was passing loose evacuations many times in the day. On Sept. 2nd a large trocar and canula, the size of a No. 14 English catheter, was passed through the chest-wall into the lung just above the angle of the scapula, and between it and the vertebral column it was directed forwards and outwards. This spot was chosen because it seemed to be that of the maximum density. When the trocar was withdrawn, a flow of pus through the canula continued until fourteen ounces were collected. A drainage-tube six inches long was then passed through the canula into the abscess cavity, the canula was withdrawn, the drainage-tube was secured to the skin with thread and sticking plaster, and covered with a thick absorbent dressing. Each day the dressings were changed, and at first they were always found saturated with discharge. During the dressings the patient was brought to the edge of the bed in the dorsal

recumbent position and directed to cough; by this means many ounces of pus were discharged. After the fourth day the drainage-tube was replaced by one considerably larger in calibre; this was removed daily, and after cleansing was filled with powdered iodoform, re-introduced, and blown clear into the abscess cavity. On Sept. 17th an ethereal solution of iodoform was injected through the tube into the cavity, a proceeding which almost caused death, for the glottis was thrown into spasm, and the odour of ether was very strongly perceptible in the breath. From this date she improved in a marked manner, and on Sept. 24th the discharge had practically ceased. From Sept. 2nd she took one grain of iodoform in pill every four hours, and continued to do so until her removal to the convalescent home. On Sept. 24th the measurement of the chest showed a decrease of two inches on the right side at the level of the ensiform cartilage. On Oct. 6th she complained of pain in the front of the chest, and a tender spot was exhibited in the fifth interspace immediately below the nipple. On the 9th, as there was evidence of fluctuation at this point, an incision was made through which dressing forceps were passed and opened, when a large quantity of pus came away. A drainage-tube was then introduced, filled with iodoform, as before described. In a few days the sinus closed. On Dec. 1st there was a difference of three and a half inches in the measurements of the two sides. The temperature was then 99°, the pulse 100, and the respiration 40 a minute. She was removed to St. Michael's Home near Brent on Dec. 6th, 1894, and there made an uninterrupted recovery. On March 8th the right side of the chest measured three inches and three quarters less than the left at the level of the ensiform cartilage. The whole of the lower lobe of the right lung appeared to be solid, the percussion note was absolutely dull, and no breath sounds could be detected. On March 19, 1895, she returned to her old situation, having gained over two stone in weight since Dec. 1st. She said she felt perfectly well.

AN ORIGINAL DOCTOR.—The *N. Y. Med. Rec.* gives the following account of a quaint and original doctor located in one of the islands of Puget Sound.* He advertises in posters and placards printed in a home outfit. In one of his announce-

ments he says: "Legs and arms sawed off while you wate without pane. Childbirth and tumors a specialty. No odds asked in measles, hooping cough, mumps or diarrrear. Bald head, bunions, corns, warts, cancer and ingrowing tow nales treated scientifically. Coleck, cramps, costiveness, and worms nailed on sight. Wringworms, pole evil, shingles, moles, and cross eye cured in one treatment or no pay. Private diseases of man, woman or beast eradicated. P. S. Terms invariably in advance. No cure, no pay. P. S. (Take Notis.) No coroner never yet sot on the remanes of my customers, and enny one hiring me doant haf to be good layin' up money to buy a gravestone. Come won, come awl."

This man is said to do a good business, although you would not expect it, and his patients say he cures disease, and does it thoroughly and quickly.

TESTING FOR SUGAR.—In Dr. S. Solis-Cohen's clinic, *Coll. and Clin. Record*, Boettger's bismuth test is first employed, equal parts of urine and officinal liquor potassæ to which a pinch of bismuth subnitrate has been added, being boiled for some minutes in a test tube. Prolonged boiling is necessary to be sure of the correctness of a negative result. If sugar is present, a black precipitate of metallic bismuth is deposited. Gray discoloration may occur with substances other than sugar, and while such a change causes the case to be watched and repeated examinations of the urine to be made, it is not considered conclusive of glycosuria in the absence of confirmatory evidence. If, after prolonged boiling, no change of color occurs, the bismuth subnitrate remaining undecomposed and retaining its whiteness, the conclusion is drawn that sugar is not present and further tests are not undertaken. If the black deposit is obtained, this, as a rule, means that sugar is present; still, in order to guard against possible errors, Fehling's test with alkaline tartrates and cupric sulphate is then additionally used. If this likewise gives a positive result, the qualitative examination is considered sure and quantitative determination of the amount of sugar is undertaken either by Fehling's method or by fermentation in Einhorn's saccharometer.

THE USE OF CHLORAL EXTERNALLY.—Dr. Brodnax, *La Semaine Médicale* in *Medical and Surgi-*

cal Reporter, June 1, 1895, gives the following formulæ for the external and local use of chloral hydrate :—

In *Cutaneous Pruritus* from urticaria, measles or other eruptions :—

R—Chloral,
 Carbolic acid, āā 50 (gr. xijss).
 Olive oil, 50 (℥ jss. gtts. xxx).

Apply locally.

In *Toothache* :—

R—Chloral,
 Camphor,
 Carbolic acid,
 Glycerine, āā 5 (℥ j. ¼).

Introduce a ball of cotton moistened with this mixture into the cavity.

In *Earache* :—

R—Chloral,
 Camphor,
 Carbolic acid, āā 50 (gr. xijss).
 Castor oil, 15 (℥ iv).

Instil a few drops of this mixture, previously warmed.

In *Acute Coryza* :—

R—Chloral, 50 (gr. xijss).
 Castor oil, 15 (℥ iv).

If applied to the nasal mucous membrane, after cleansing of the surplus mucus, this mixture will arrest the secretion, calm the irritation of the mucous membrane, as well as the accompanying headache.

DISINFECTATION OF TUBERCLE-INFECTED HOUSES.

—After a careful study of the effects of various disinfecting agents on the growth and development of the tubercle bacilli, Drs. Dilepine and Ransom sum up as follows :—

1. The disinfection of rooms which have been contaminated with tuberculous products cannot be obtained by means of the fumigation methods generally used at present. Sulphurous acid, and chlorine, as used under supervision by experienced municipal disinfectors, have proved practically useless.

2. The only other method of disinfection which seems to promise more satisfactory results is the direct application of a solution of chlorinated lime to the walls to be disinfected. This method has so far given satisfactory results, but is at-

tended with discomfort on the part of those who have to carry out the disinfection.

3. Light is, in the case of the tubercle bacillus, the most important natural disinfecting agent.—
Brit. Med. Jour.

PROGNOSIS OF CEREBRAL HÆMORRHAGE. — Alfred G. Barre, M.D. Edin., F.R.C.P. Lond., *Brit. Med. Jour.*, May 18, 1895, in a lecture on this subject delivered at the General Infirmary, Leeds, sums up as follows: In any case of apoplexy due to hæmorrhage into the hemisphere, if renal disease, Cheyne-Stokes respiration, or hyperpyrexia, any one, two, or all three be present, the patient will in all probability not recover. If no one of these is present, and does not make its appearance, he may, and probably will, recover, however long insensibility may last and however deep it may be.

The presence of other serious conditions, such as diabetes, chronic alcoholism, typhoid fever, or idiopathic anæmia, will, I have no doubt—for I have seen examples to this effect—exert just as fatal an influence as renal disease upon the course of sanguineous apoplexy.

RENDER THE INTESTINAL CANAL ANTISEPTIC.—

The *Materia Medica* gives at least one safe intestinal antiseptic. It is Salol. Professor Hare, in the last edition of his *Practical Therapeutics*, says that Salol “renders the intestinal canal antiseptic, and so removes the cause of the disorder, instead of locking the putrid material in the bowel, as does opium.” He regards Salol as “one of the most valued drugs in the treatment of intestinal affections.” Have we a substitute for opium for the relief of pain? Here comes in the American coal-tar products, the first of which, for the relief of pain, stands Antikamnia. Therefore, we conclude that to remove the cause, to render the intestinal canal antiseptic, we have an invaluable remedy in Salol; while to remove accompanying pain, to quiet the nervous system, and to reduce any fever which may be present we have a remedy equally efficacious in Antikamnia; an ideal combination for the treatment of this large class of diseases, and we may specially cite Typhoid Fever. These two drugs are put up in tablet form, called “Antikamnia and Salol Tablets,” each tablet containing two and one-half grains of Antikamnia and two and one-half grains of Salol.

AMERICAN DERMATOLOGICAL ASSOCIATION.—The nineteenth annual meeting of this Association is to be held at the Windsor Hotel, Montreal, on September 17th, 18th and 19th, and gives promises to be one of the most interesting in the history of the Association.

Officers for 1895: President, S. Sherwell, M.D., Brooklyn, N.Y.; Vice-President, J. A. Fordyce, M.D., N.Y.; Secretary and Treasurer, C. W. Allen, M.D., 640 Madison Avenue, New York.

THE AMERICAN ASSOCIATION OF ORIFICIAL SURGEONS will hold its eighth annual session at Apolo Hall, Central Music Hall, corner Statr and Randolph Sts., Chicago, on September 4th and 5th

An interesting programme has been prepared, consisting of papers of a practical nature.

Books and Pamphlets.

THE FUNK AND WAGNALLS STANDARD DICTIONARY OF THE ENGLISH LANGUAGE. Single-volume edition: Half Russia, \$12; full Russia (with Denison's Patent Reference Index), \$14; full Morocco, \$18. Two-volume edition: Half Russia, \$15; full Russia (with Denison's Patent Reference Index), \$17; full Morocco, \$22. New York: Funk & Wagnalls Company, 30 Lafayette Place. Toronto: 11 Richmond Street W.

We all knew that when a wealthy American firm start out to "beat all creation," they spare neither labor nor expense to do it. Funk & Wagnalls have done it, in making what is no doubt the best dictionary of the English language that has ever been made. The colossal style in which the work was undertaken will be a surprise to many, as it was to us. When we say that 247 editors and specialists, and 500 readers for quotations were engaged upon this work, and that it cost nearly one million dollars, our readers will be able to form some conception of the amount of work put in upon it. The editors engaged upon the various departments of the dictionary have been selected from the front rank of English and American scholars; each is representative of all that is latest and most approved in his own field of exploration and research; and each is an accepted authority in his sphere. From beginning to end, the Standard Dictionary is the work of men thoroughly equipped in the schools of science,

literature, and art, and of experts in all handicrafts and trades. It is neither extravagant nor invidious to say that no more capable and vigorous body of workers, has ever been called to the making of a dictionary in any language. As has been well said, "This Dictionary is, in fact, the joint product of many minds, reflecting the whole scholarship of the present age." It embodies many new principles in lexicography, contains 2,338 pages, 5,000 illustrations, made expressly for this work; 301,865 vocabulary terms, which is nearly two and one-half the number of terms in any single-volume dictionary, and about 75,000 more than in any other dictionary of the language. Space at our disposal is utterly inadequate to mention a thousandth part of the good points of the work. Suffice it to say, that it is the best dictionary, by far, that we have ever seen, and covering the ground so fully as it does, ever expect to see. It is a better general library in itself than most men possess.

THE POCKET MATERIA MEDICA AND THERAPEUTICS. A *Résumé* of the Action and Doses of all Official and Non-Official Drugs now in common use. By C. Henri Leonard, A.M., M.D., Professor of the Medical and Surgical Diseases of Women and Clinical Gynæcology in the Detroit College of Medicine, Member of the American Medical Association, etc. Second edition, revised and enlarged; cloth, large, 16 mo., 367 pages. Price, post-paid, \$1. Detroit, The Illustrated Medical Journal Co., Publishers. 1895.

The second edition of this popular therapeutic work has had sixty-seven pages added to it, besides typographical errors corrected, etc. A new and complete cross-index has been prepared, which renders the quick finding of a non-familiar drug possible. This is an important feature lacking in ready-reference books. The descriptive arrangement of the drugs is as follows: Alphabetically, the drug, with its pronunciation [(official or non-official standing indicated), genitive case-ending, dose and metric dose. Then the English, French and German synonyms. If a plant, the part used, habitat, natural order, botanic description, with alkaloids, if any; if a mineral, its chemical symbol, atomic weight, looks, taste, how found, its peculiarities. Then the action and uses of the drug or compound, its antagonists, its incompatibles, its synergists and then antidotes. Then follow its official and non-official preparations with their medium and maximum doses. Altogether it is a handy volume for physician, druggist or student, and will be frequently appealed to if in one's possession.