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THE
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EDITOR:

ADAM H. WRIGHT, B.A., M.D. Tor.

ASSOCIATE EDITORS:

JAMES F. W. ROSS, M.D. Tor. JOHN CAVEN, B.A., M.D. Tor.

EDMUND E. KING, M.D. Tor.

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CHAIRMAN'S ADDRESS.*

MR. B. G. CONNOLLY.

YOUR HONOR, guests, members of the Faculty, and fellow-students :
In opening this, the ninth annual dinner of the Medical Faculty in the University of Toronto, it affords me the greatest pleasure to extend, on behalf of the faculty and students, to our guests this evening a hearty welcome, and I earnestly trust and desire that you will enjoy our hospitality to the utmost. This is the one evening of the year when it is our privilege to have with us and to unitedly entertain those to whom we are in many ways indebted ; but I must confess that our entertainment is not without the alloy of selfishness, as we are looking forward with no small degree of pleasure and anticipation to the addresses which are to follow.

Among those who grace our halls to-night are representatives of Church and State, of Bench and Bar, of the professor's chair and the practitioner

* Delivered at the banquet of the Medical Faculty of the University of Toronto, December 5, 1895.

in harness, of the press, the medical associations of our county, and of sister institutions, from all of which members shall, in due order, be called to address you, assured of a cordial hearing whether the speaker stands clothed with scholarship and experience or has only to recommend him youth and its aspirations. Our dinner to-night has more than its ordinary significance, for, although our announcement shows this to be our ninth dinner—and rightly so, referring to our reorganization—yet in reality we to-night attain our majority, as this is our twenty-first gathering as a medical educational body. Dr. Graham, in replying to one of the toasts a couple of years ago, gave a pleasing sketch of the growth of banquets of this kind, as he was at the first, which was held in the Walker House twenty-one years ago. It is very appropriate, that Dr. McPhedran who took an active part, as an undergraduate, in organizing our first dinner—in fact, the first of the kind in Canada—should occupy the chair of honorary president on this occasion, as he does to-night. It is usual to celebrate important events in individual life by rejoicing; and so with us—we want everything to bespeak the joy we feel. We want music and song and good cheer to reign. We invite the freest speech, and we trust all will enter in with spirit to make our evening characteristic of our college life, where well-ordered freedom prevails, and the pleasing intercourse of teacher and student marks our daily labor, governed only by the dictates of courtesy and respect.

It has been customary, at these our annual gatherings, for the one who occupies the position I now fill to outline briefly, as far as concerns us, the progress of the year, and happily there is much that might occupy my attention: for at no time in the history of our faculty has more valuable work been done; at no time has the opportunities which it offers to students been greater; and never has the high standing of our university received more deserved recognition abroad. However, with some of these matters all are familiar, and others will be treated by distinguished speakers who are to follow; so they call, in my remarks, for the merest mention.

A year has passed since last we assembled here, and, though quick its flight, it bears the marks of progress and of change. A brilliant class has left us, and we have been joined by one of promise. The class of which I am a member has taken another step towards assuming the responsibilities of those who practise medicine. The results of the efforts of our students at the various examinations have been satisfactory, indeed, while on the field of athletic sports ours has been a march of triumph. The completion of the new chemical laboratory, the opening of the museum in connection with the biological building, and the increased facilities for study provided in the "old school," all bear marked evidence to the

progress of our *alma mater*, and the generosity of those to whom is entrusted its management. No single feature for the year affords a more pleasing topic for reference than the course of lectures now in progress on the history of medicine, in which will be traced the growth and development of our art from the earliest times, when it stood surrounded by the mists of empiricism and superstition, from which it slowly emerged and advanced through varying vicissitudes, until it now stands firmly planted on the rock of science.

It is pleasing because there is an inexpressible charm in the lives of the good, brave men whose only objects have been to relieve pain and save life ; and while in the annals of medicine there have been those who preferred self-glorification to honesty, and were prepared to sacrifice every principle to attain it, yet history teems with accounts of those who, by years of labor, by close observation, and by patient research, have reduced medicine to science, and placed it in a position to defy the attacks of faction and command the respect of all.

The history of medicine—medicine in its widest sense, as referring to the study of causation and prevention of disease, its treatment, and the alleviation of human suffering—affords a further pleasure in showing the immense strides which have been taken in advance, more particularly in the last half century. Among those, in later years, who have done much for medicine, no name stands more prominently forward than that of the late illustrious Louis Pasteur, whose death was mourned by the world, and whose remains were accorded by his sorrowing countrymen a funeral befitting his position of prince among men. Although not a member of our profession himself, we profit by his work, and to him be all credit given. No elements of chance assisted him in his labors. He had fixed principles for a guide, and successes such as few men know were his, as, one by one, the knotty questions that he attacked yielded to his piercing scrutiny. Whilst he enriched science by his many discoveries, yet the most important legacy he has left us is the inspiration of his name and the example of his life, wherein is illustrated the wonders which persistent, intelligent, well-directed efforts will accomplish.

From our profession nature yet holds many problems unsolved, many secrets undiscovered. The future is full of possibilities. What share of the harvest will be reaped by the graduates of the University of Toronto it is not easy now to say, but conversant as I am with the training and opportunities which she offers them as students, and knowing the distinguished work some of her graduates have already done, I may be pardoned for predicting that theirs will be a goodly part. Our esteemed professor of physiology paid a solid tribute to our graduates in his address last year when he predicted that, in time to come, our faculty, as occasion demanded,

would be increased and recruited from her own graduates. Such can only be considered as a step in the right direction—a true encouragement to merit. Our best men should be kept at home, and to their alma mater should belong the credit of their labors. We all hope for the time when there will be provided some institute of research where those whose tastes lie in that direction will be allowed to pursue, under proper supervision, the work of their choice. The endowment of such an institution by the government would be in the public interest. It is generally admitted now that when the cause of disease is clearly known, the effect can be more easily removed, or, better still, prevented. The medicine of the future is preventive. Knowing this, it becomes our duty to teach it, and when we who are now students go out into practice, to lose no opportunity of educating public opinion as to the necessity of an institute such as that to which I have referred. I think if such an institute were properly launched, the character of the work done would be its best appeal for support and the extension of its usefulness. Something of the kind, encouraging original investigation along the lines of physiology, physiological chemistry, biology, pathology, and bacteriology, must greatly increase the knowledge we now possess, and which has done so much in the way of preventing disease and led to the hope that in years not far distant many of the diseases now so prevalent will be known only as curiosities. Sufficient illustration of what has been done is seen in the improved treatment of diphtheria, and in the fact that septicæmia is all but wiped out by the advent of the use of antiseptics.

That disease will ever be completely wiped out is beyond the hope of the most sanguine; but if through the efforts of the profession in introducing good sanitary precautions, by the advocacy of correct habits of living, and by the successful treatment of disease, the average of life is lengthened to any appreciable extent and human suffering lessened, then it has not worked in vain.

It is not only along the lines of research and investigation in the sciences which lie at the bottom of medicine, and which present such a fascinating field, that improvement has been made, but also in applying the knowledge thus acquired, supplemented by the not less interesting nor less important information obtained at the bedside.

It is only by comparison with the past that we can properly appreciate all that has been done. Where once new growths could only be grouped according to gross appearance, we have now the microscope to assist in rightly classifying them and to indicate proper treatment. An early removal thus suggested may often be the means of saving life. The stethoscope enables us to detect and describe pathological conditions of lung and heart almost to a certainty where once our knowledge was based

only on conjecture. The laryngoscope brings the trachea into view, and the ophthalmoscope gives accurate information of the inmost recesses of the eye. Thus with the various instruments of precision to assist his trained touch and his knowledge of disease, the skilled doctor of to-day can diagnose the different pathological cases with readiness and certainty.

Treatment has kept pace with advance of other branches of our knowledge, and has reached a happy climax when the very germs that lie at the bottom of disease can be harnessed into producing a substance which tends to their own obliteration. The introduction of anæsthetics has greatly enlarged the field of the surgeon, and antiseptic methods lessened much of the danger of operation, so that now he may fearlessly treat the most delicate structures with the scalpel with the greatest advantage to the patient.

All this history teaches, and more, and while with the past we have nought to do, save to gather inspiration for the future, yet it must assist very much the student of to-day to appreciate his glorious heritage in the accumulated knowledge he finds to his hand, and in the varied field which spreads before him, affording employment for the highest mental faculties.

The first allegiance of the doctor is to his professional pursuits, and to those who, placing confidence in his skill, employ him. For these he must labor night and day. He must stand the repository of secrets the most sacred ; he must be the trusted adviser in disease, the sympathetic friend who will allay pain, ward off danger, sooth apprehension, and infuse hope. In all this his greatest reward is the approval and friendship of those who know best his work and in the satisfaction of useful work well done. But in a growing country such as ours his duties do not end there. He must bear his share in assisting and moulding her progress. Trusted as he is, he can do much to encourage education, foster love of country and loyalty to her institutions, and just appreciation of her advantages. In this the unwritten history of a thousand places shows how well he does his part.

The practice of medicine dates back more than two thousand years and will go on to the end of time. It will be ever popular because ever a necessity, and while, as new light directs, new methods may be introduced and treatment changed, yet the object of medicine remains the same, and common experience goes to show that in its practice he approaches nearest to success who works in accordance with loyalty to his country, justice to his neighbor, whether practitioner or patient, and justice to himself.

THE OPERATIVE TREATMENT OF TUBERCULAR GLANDS.*

BY A. PRIMROSE, M.B., C.M. EDIN., M.R.C.S., ENG.

Surgeon to the Hospital for Sick Children, Toronto and the out-door department, Toronto General Hospital; Associate Professor of Anatomy in the University of Toronto.

THE object of my paper is to indicate the technique which should be observed in the treatment of tubercular glands by excision. Tubercular adenitis is so common that every practitioner is familiar with the clinical phenomena presented by the disease. Formerly the lymphatic glands thus affected were subjected to what we may term expectant treatment, local or constitutional, and it is only comparatively recently that the radical procedure of excision has been adopted extensively. Excision was formerly advocated in exceptional cases only, *e.g.*, where tumors of considerable size had formed, causing deformity or pressure symptoms; or, again, operation was resorted to in cases in which suppuration had supervened and an abscess demanded incision and drainage. The question of "operative *versus* expectant treatment" has been discussed in connection with these glandular affections just as extensively as a similar question has been discussed with regard to other tubercular conditions, notably of the bones and joints. The same arguments for and against operative interference are advanced respecting the treatment of these lymphatic glands as are put forward concerning tubercular arthritis. The fact is proven in both cases that tubercular processes may become quiescent, and their activity may cease. It is equally true that in both cases the disease may run a rapid course, and may even prove destructive to life or limb.

I do not propose in this paper to discuss the question of appropriate treatment in the broader sense, but I wish to state emphatically my conviction that if active local measures are to be adopted nothing short of excision should be attempted. British surgeons seem to be of one opinion on this point; thus I may refer you to the discussion on "The treatment of enlarged cervical glands" at the meeting of the British Medical Association at Newcastle, in 1893. The discussion was opened by Mr. Clifford Allbutt and Mr. Teale, and was taken part in by Messrs. W.

*Read before the Simcoe District Medical Society.

Knight Treves, Godlee, Howard Marsh, Noble Smith, and others. It is noteworthy in that discussion that Mr. Howard Marsh, who is such a strong advocate of expectant treatment in tubercular arthritis, strongly recommended surgical interference by operation in tubercular adenitis. Dr. T. Barlow, in summing up the points brought out at that meeting, referred to the fact that the only difference of opinion, expressed during the discussion, was that concerning the technique of the operation: it was clear that the drug treatment of tuberculous glands was at a discount: drugs, he said, were of use for improving the general nutrition, but had little demonstrable effect on masses of caseous material.*

It is self-evident that the field of operative procedure in the treatment of enlarged lymphatic glands is restricted to those localities in which the glands are accessible. Thus the cervical glands may readily be removed. I have also removed axillary and inguinal glands, and glands from the pelvic region along the iliac vessels. Glands, however, of the chest and abdominal cavities are rarely within the possible field of operation. For instance, the bronchial glands, the mesenteric, and retroperitoneal glands cannot be successfully attacked. It is true that occasionally an abscess may develop, say, in the retroperitoneal region, in consequence of infection lodged in the group of glands there situated: such an abscess may be opened and the principles of treatment, which I am about to advocate, may be applied there as in more superficial parts. The locality, however, which is most frequently attacked by the surgeon in these cases is the neck region; probably the cervical glands are more frequently infected by tubercle than any other group: this is the opinion one would form from clinical observation. We are not surprised that such should be the case, because infection may here occur so readily from the mouth cavity and the upper air passages. These glands are more exposed to irritation than any other group; they have more work to do in removing irritative and infective material, absorbed from the mucous and cutaneous surfaces than any other group of glands. Hence these cervical glands, because of the increased functional activity, are often the seat of inflammatory processes, and tubercular inflammation is very commonly the result of infective absorption.

The etiology, therefore, of tubercular adenitis is readily understood. It may briefly be stated to be due to peripheral irritation of skin or mucous membrane, more frequently the latter. Thus the tubercular infective material may be absorbed by the lymphatics of the nose or mouth, and, passing along the lymphatics, this is lodged in the glands towards which the different lymphatics run. The gland in its functional activity has been compared to a filter, removing from the lymph stream particles which

would flow on into the blood were it not for the interposition of the gland. The glands of the cervical group which are most frequently affected are those which receive their afferent lymphatics from the nose and mouth region ; this is what we would expect, from the fact that the tubercle bacillus is so frequently found in the buccal and nasal cavities. Lastly, we must note the fact that slight abrasions of the surface are very common in these cavities, and under such circumstances of peripheral irritation infective absorption is much more apt to occur.

In connection with the etiology of the disease, it is worth noting the fact that tubercular infection may be produced by direct inoculation. The following case appears to be an example of inoculation by vaccination. L.C., æt. 10, was admitted under my care in the Hospital for Sick Children, with the history that she had been vaccinated six months previously. The vaccination was done over the left deltoid muscle, and the ulcer which resulted never healed. One month after vaccination a discharge occurred from the right ear : immediately after this a lump formed in front of the left ear, then another on the right side of the neck ; three weeks subsequently a lump in the left axilla. On admission sinuses were discharging from the right side of the neck and from the left axilla. The right ear was discharging stinking pus. There was a hard swelling immediately above Poupart's ligament on each side. The vaccination marks were represented as raised oval patches, the larger one about $1\frac{1}{2}$ inches long, and $\frac{3}{4}$ inch broad. The posterior one was slightly smaller. The surfaces of the patches were granular in appearance after the encrustation present on them was removed. The skin in the immediate vicinity was healthy in appearance.

I excised the patches freely, and removed and scraped away as much of the unhealthy glandular and cicatricial material in the neck and axilla as possible. On microscopic examination of the glands, I found typical tubercles, with large numbers of giant cells. I could not discover any giant cells in the vaccination patches, but groups and columns of epithelioid cells were abundant. The case seemed to me to be one in which inoculation of the bacillus tuberculosis had been caused at the time of vaccination.

The course of the disease varies. It may be acute or chronic. I may here narrate briefly the history of a well-marked type of the acute process. A child, $4\frac{1}{2}$ years of age, was admitted under my care in the Hospital for Sick Children on the 28th of August, 1893. A few days previously the child had been playing on the street, and came home complaining that he had been run over. The mother could, however, find no evidence of injury. On the following morning, he complained of pain in his leg, and, on examination, a lump was discovered in the left groin

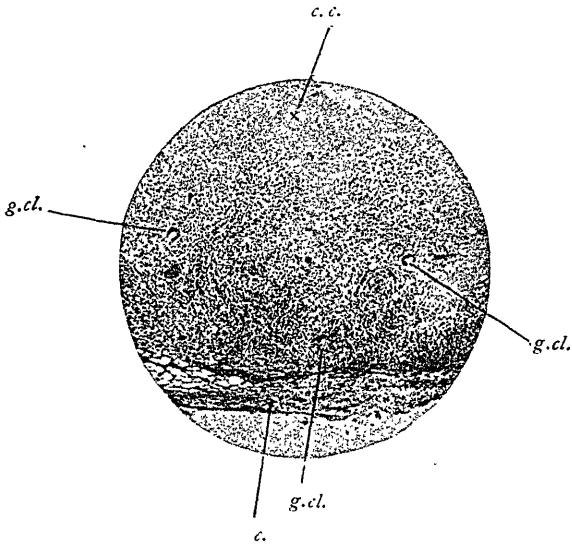


PHOTO-MICROGRAPH OF A SECTION OF A TUBERCULAR
GLAND REMOVED FROM THE INGUINAL REGION
OF A CHILD IN THE CHILDREN'S HOSPITAL
X 30.

c. c. Caseous centre.

c. Capsule (thickened).

g. cl. Giant cells, showing the typical horse-shoe arrangement of their nuclei.

Electric oil was rubbed into the part for three days, but no good resulted. The lump got harder and increased in size, and he was brought to the hospital. The child had previously been strong and healthy. There was no history of consumption in the family. During four days in the hospital, previous to operation, the lump increased appreciably in size, and the temperature varied from 101° to 104° . At the time of operation a large, irregular mass existed in the left groin, immediately below Poupart's ligament; this was removed by a vertical incision, and proved to be composed of a mass of enlarged glands of the superficial femoral group. Another mass was found about Poupart's ligament, and, by means of an incision through the abdominal wall, parallel to and above Poupart's ligament, three large glands were removed from the region of the iliac vessels. The wounds were both flushed with 1-40 carbolic acid lotion and packed with iodoform gauze. The temperature fell after the operation, and the wounds healed readily.

The glands were examined microscopically, and were found to contain typical tubercles. The case is of considerable interest from the fact that, although the process was very acute, yet there was absolutely no suppuration. The tubercular process is a non-suppurative process; the bacillus tuberculosis is non-pyogenic, and when pus does occur, as it not infrequently does, it is due to mixed infection. Usually some pyogenic cocci have found their way, by absorption from the periphery, to the glands in which tubercular infection has occurred, and they there find a suitable nidus for their growth and development.

Another child, $2\frac{1}{2}$ years of age, came under my care, in whom the glands of the left groin had been similarly affected, in consequence of an injury received five weeks previously. I removed the horizontal group of left inguinal glands. In connection with these a small abscess had developed. In this case the wound was closed by suture, and healing occurred by first intention. The glands, under the microscope, were found to contain numerous giant cells and epithelioid cells, and the bacillus tuberculosis was demonstrated. These cases are good examples of acute tubercular adenitis. The chronic variety of the disease is more common, and is familiar to every practitioner.

Thus in the cervical group of glands we find small masses which tend to increase in size. At first they are freely moveable, and they remain so for a varying period. Often we find glands as large as a walnut, which move readily on an manipulation in the deeper tissues. As the disease advances they tend to become fixed in consequence of the development of inflammation in the periglandular tissue, and an abscess may develop in the gland, or more frequently in the inflamed tissue round about the gland. These abscesses burrow and eventually point on the surface, and, if left to

themselves, open spontaneously ; the discharge continues for a time, until nature has got rid, by this means, of the infective material and the necrotic debris, and eventually healing takes place, leaving usually an unsightly scar.

We may now consider the pathology of tubercular glands. The gross pathological appearances vary greatly, ovoid masses varying in size, the consistence much firmer than the normal gland. At times the enlarged gland becomes softened, and this softening does not appear to bear any definite ratio to the size attained. Thus I could show you glands which I have removed from the neck an inch and a half long, in which no softening has taken place, while, on the other hand, glands of very much smaller size may be soft and caseous. Suppuration in connection with tubercular glands is the exception, for the reason which I have stated. When a gland becomes tuberculous there is always an attendant process of inflammation of a low, non-specific type, surrounding the infected area. This remark applies to all tubercular processes, glandular or otherwise. It appears to be in this neighboring area of inflammation that pyogenic microbes are apt to lodge. Pus may form within the gland capsule, round about the tubercular focus, or, what is more common, it forms without the capsule in the tissues, which have become involved in a periadenitis. The gland may become wholly destroyed in the suppurative process, so that occasionally no trace of the glandular tissue is recognizable. The caseous material found in a gland is simply necrotic debris. The periadenoid inflammation may lead to other complications than suppuration ; the surrounding tissues are implicated and the inflammatory material may organize, and the gland thus becomes firmly adherent to the surrounding parts. Lastly, the gland capsule itself becomes thickened during the progress of the disease.

The histological characters also supply certain indications for treatment. If a thin section exhibits a mottled appearance if held up to the light, this is due to collections of epithelioid cells, and I believe the appearance is very suggestive of the presence of the tubercular process. Compare with this the condition found in lymphadenoma, and you will see that in the latter case there is a uniformity in the section and the mottling is absent. Under the microscope one may detect little else than caseous debris in cases of long standing, but if examined carefully, one is pretty sure to find, under the capsule, collections of epithelioid cells. I show you a micro-photograph of a section of a gland under the lens, which gives you a picture of the condition commonly found.

The centre of the gland is caseous, the capsule is thickened, and between the capsule and the caseous centre is gland tissue in which the tubercular process is actively going on. I have nothing to

say with regard to the caseous centre or the thickened capsule, but the part immediately within the capsule deserves special attention. Here we have an active process going on, or at all events we have here the portion of the gland in which active disease is apt to be lighted up when stimulated to do so. This area of activity (or it may be in a quiescent state) possesses certain characteristic appearances under the microscope. Thus we may find collections of the so-called typical tubercles. Each tubercle is composed of a central giant cell, with its many nuclei frequently arranged in a horse-shoe shape near portions of the periphery of the cell. Surrounding the giant cell is a zone of epithelioid cells, and surrounding these another zone of round cells (leucocytes), or instead of the "typical tubercle" we may have the condition described by Watson Cheyne, in connection with tubercular bone disease, as "tubercular infiltration," in which we have collections of epithelioid cells, often arranged in groups or columns, with leucocytes surrounding these. Lastly, bacilli may be demonstrated by appropriate methods. The bacillus tuberculosis is usually found in the giant cell, occupying a position in groups towards the centre of the cell, away from the nuclei. The bacilli, however, are to be found also in the epithelioid cells, and it is now held that they are more constantly present in the epithelioid cell than in the giant cell. From this circumstance, Mr. Watson Cheyne was led to assert that he looked upon the epithelioid cell as the characteristic element of the tubercular process.*

Treatment. The principles to be observed in treating tubercular glands by excision are simple. It is none the less important that they should be rigidly observed. The suggestions I make are based upon a careful study of the pathological conditions found and upon my experience in the operative treatment of these cases.

We must endeavor to perform our operation in such manner that we leave an aseptic wound. We are dealing with a septic process, and therefore the use of suitable antiseptics is indicated. Carbolic acid is probably the best form of antiseptic available for our purpose. The operation should be performed with strict observance of the principles of antiseptic surgery as enunciated by Lister. I need not detain you with the details. Our efforts must be directed towards ridding the tissues of the infective material and preventing infection of the open wound during the process.

The incision should be made so as to expose the gland by a clean cut, with as little bruising of the tissues as possible. The line of the incision, when on exposed surfaces, should be determined so as to leave as little noticeable scar as possible. Thus in the neck one may often be able to make the incision along certain natural creases or furrows in the skin and

**British Medical Journal*, 1889, Vol. II., p. 1228.

the linear cicatrix which results can hardly be discovered. I am not an advocate, however, of making the superficial incision at a remote point and dissecting up the tissues until the gland is reached. This method has been recommended in the neck in order to avoid the appearance of a scar on the exposed portion of the neck ; the connective tissue is opened up very extensively and a very large subcutaneous wound made, through which infection may readily occur over a wide area. I believe this to be an exceedingly dangerous procedure.

When the gland is reached and exposed it is best removed by a clean dissection. When early attacked the gland may be dislodged by enucleating it with the finger nail, but if there have been any strong adhesions formed to the surrounding parts these are best divided by means of knife and dissecting forceps. Occasionally the gland is so matted to the surrounding tissue that it cannot be defined ; the only method of proceeding in such cases is to scrape out the central caseous mass and remove by scraping, and possibly by aid of the dissecting forceps and scissors, as much of the gland and capsule as can be thus detached. If an abscess exists, its relation to the gland must be made out. It will not do to simply open the abscess and drain ; we must remove the cause of the suppuration here as in the other cases of pus formation. Evacuate the contents, then scrape the walls thoroughly, then hunt for the gland, and not infrequently we will find the gland outside the abscess wall, and communicating possibly with the cavity by a small opening. I was able to demonstrate this to my class of students a short time ago when, after opening a tubercular abscess in the neck, and thoroughly scraping and cleansing it, I found on careful examination a gland about the size of a hazel nut lying outside the abscess wall, and communicating with the abscess cavity by a small flask-like opening. The condition was, of course, due to the fact that the abscess had developed, not in the gland, but in the tissue round about it, and the gland formed practically part of the abscess wall.

The use of lint or gauze, introduced on a pair of pressure forceps, will be found very useful to swab out the cavity of an abscess or of a caseous gland ; the caseous detritus may thus be removed very efficiently. After thus thoroughly cleansing the cavity, further caution is required in order to secure a good result. We must remember that the pus and the caseous material may be entirely removed, and yet the actively tubercular tissue *immediately under the capsule* may be left. We have removed it as far as possible by scraping, but a further safeguard should be employed, and this is best done by the use of pure carbolic acid. This may be introduced on a little piece of absorbent wool held in a dressing-forceps, and the interior of the cavity thoroughly swabbed with it. After such treatment, if we feel confident that we have an aseptic wound, we may unite by

suture, and in many such cases I have had healing by first intention. If there is doubt, however, it is best to pack the wound cavity with iodoform gauze, and allow it to granulate. We use iodoform in preference to other antiseptic packing, because iodoform seems to be particularly beneficial in destroying the tubercular process. Occasionally we have cases in which we do not require to pack, and yet, in consequence of the extent of the wound, the opening up of connective tissue, and the oozing, it is wise to insert a drainage tube for a few hours.

Sometimes the adhesions about a gland in dangerous regions are so extensive that we are unable to remove it. Important structures may be implicated in the adhesions, and we are forced to leave the gland. This condition is, however, rarely such that we are compelled to abandon the gland without removal. On one occasion, in assisting Mr. Cameron in the removal of glands deeply situated in the posterior triangle, we found the phrenic nerve so firmly united to the gland that we were compelled to leave the gland in place: slight traction of the gland caused spasmodic contraction of the diaphragm. Often a gland is adherent firmly to the superficial parts, and yet may readily be stripped off its deeper connections. I have dissected such glands off the internal jugular vein, baring that vessel without damaging it, for a considerable distance.

Lastly, let me say one word with regard to the treatment of cicatricial tissue and sinuses in long-standing cases. This tissue is often the seat of tubercular infiltration, and should be carefully and thoroughly removed. Many of these cases run a prolonged course because the infected material which is here referred to is not excised. So-called hypertrophic scars are often of this nature; they are the seat of tubercular infiltration, and require radical measures for their removal.

With regard to the danger to life of the operation of excision, I may quote from the large experience of Mr. Knight Treves, who states that he has operated on a few hundred cases and has never had a death.

I believe that in the future more of these cases will be subjected to the operation of excision than in the past. Practitioners are beginning to realize the fact that palliative measures tend to make matters worse. I believe nevertheless that Mr. Thoms, of Birmingham, is correct when he states* that "physicians are much inclined to persevere with local remedies, which often cause a chronic cellulitis and make the subsequent removal much more difficult."

* *British Medical Journal*, Vol. II. 93, p. 1,143.

TUBAL PREGNANCY DIAGNOSED BEFORE RUPTURE. CÆLIOTOMY AND RECOVERY.*

BY W. R. NICHOLS, M.D.,
BADEN.

WHEN that fearless pioneer in abdominal surgery, Mr. Lawson Tait, in 1883, had the courage of his convictions to remove a tubal pregnancy, it was not simply an abdomen that he opened—it was a new and victorious field on which he placed the surgeon's beneficent standard. As a consequence of the impetus given to the study of the subject by his work and teaching, cases at this date, fairly numerous, have been reported from every civilized country where women have been rescued at the brink of the grave and restored to society as its most useful members. Our own country has furnished its quota in the hands of Howitt, McKinnon, Ross, Temple, Smith, and others.

It had long been supposed that the condition of ectopic pregnancy was exceedingly rare; but in a series of 3,500 general autopsies made by Dr. Formad, of Philadelphia, there were found not less than thirty-five cases, or one per cent. ! Surely frequent enough to put every thoughtful physician on the alert.

As a practical subject, it can never become devoid of interest. The difficulties of diagnosis even after rupture, the suddenness of the symptoms during apparent excellent health, the immediate and imminent danger to life, and the absolute necessity for a capital operation to give even a chance for life—all combine to render the subject of profound interest and importance to the general practitioner, as well as to the surgeon and gynæcologist.

In regard to the diagnosis before rupture, the symptoms are generally so mild that the patient does not seek relief from her physician; and if she does, these symptoms are not differentiated from those that belong to minor ailments. On this point Mr. Tait says: "The strangest thing to me is that in the enormous experience I have now had in tubal pregnancy (thirty-nine cases in 1889), I have never but once been called upon

* Read before the Toronto Medical Society, Nov. 5, 1895.

to make an examination until rupture occurred, and in that case there was neither history nor symptoms which enabled me to do more than determine there was *tubal occlusion*. Under these circumstances, I think I may be excused for maintaining a somewhat sceptical attitude towards those gentlemen who speak so confidently of making a certain diagnosis before rupture." And Mr. J. Bland Sutton, in his work on "Surgical Diseases of Ovaries and Fallopian Tubes," 1893, the most recent and valuable work on the subject, states that he is acquainted with but one instance of diagnosis before rupture, which was made by Dr. Herman, senior obstetric physician to the London Hospital.

History.—Mrs. T., æt. 37. German, parents living and healthy. Had nine brothers and sisters, of whom five died in infancy from "teething"; those living are healthy. Menstruated first in fourteenth year, and continued regularly thereafter, unless physiologically suppressed.

Married at 21. Has had 11 living children, and one miscarriage at 4½ months. Two children died in infancy, remainder healthy. After second confinement had "inflammation." Attending physician thought an abscess would form on left side in inguinal region, but it passed away, leaving, however, more or less tenderness ever since. Ten years ago cough, expectoration, and hæmoptysis occurred; patient remained poorly a few years, but improvement set in slowly, and she has not been troubled for four years to any serious extent.

May 24, 1894, was delivered of a strong, healthy child; everything normal; made rapid recovery.

June 2, 1895, had a miscarriage at 4½ months. Membranes enveloping child at birth; rapid recovery; had some sanguineous discharge for week or two, but no chill, headache, or fever. It was patient's habit to menstruate soon after delivery, whether nursing child or not. She was, accordingly, unwell on July 12, again on August 11, but had no further show until washing on Sept. 15, when she was taken with a sudden and severe pain in the lower part of abdomen, on left side and back, accompanied by a gush of clear fluid, one to two ounces in quantity, from the vagina. She felt quite weak and faint for an hour or two, but was free from marked pain or discharge until the 20th, when another severe pain was experienced, followed immediately by a hæmorrhage, simulating menstruation, until the 26th, when it gradually lessened so as to disappear by Oct. 3. Patient felt so well that she went away on a trip for twelve days, during which time occasional losses occurred, but no membranous shreds were found at any time.

Was called in on Sept. 15. Found patient fairly well nourished, but somewhat anæmic. An examination of heart, kidneys, and skin showed them to be normal in condition and function. Upper lobe of right lung

consolidated (arrested phthisis). Temperature and respiration normal. Pulse, 90.

A bimanual examination of the pelvic organs revealed a uterus only slightly enlarged, with a cervix but little softened, and a fulness rather than a distinct mass on left side of uterus; no special tenderness; no collapse or signs of hæmorrhage internally. Patient could not say whether she was pregnant or not, as she was not usually troubled with morning sickness, etc. Was ordered to rest in bed, and to send for me if any further unpleasant symptoms happened before my next visit. Two examinations between the 20th and 30th enabled me to make out a distinct tumor occupying the left Fallopian tube; felt circumscribed to the touch, but had no inflammatory tenderness in it. Some pulsation could be felt in the vault of the vagina immediately beneath; no fluctuation could be elicited. A distinct sulcus between it and the uterus could be made out, both above and beneath. The ovary was also detected external and posterior to it. At the first examination a strong suspicion of the condition arose; at the next two I was satisfied with the diagnosis, and was about making a final examination before announcing it, when the patient, feeling so well, and wishing to avail herself of an interdicted excursion, suddenly took French leave as the surest way of attaining it. On her return on the 17th an examination was again made, which only confirmed my previous opinion.

To account for the first severe pain, and its accompanying loss of clear fluid (which was not blood), it was necessary to consider the following as probable sources, viz.: Rupture of amnion in uterus (abortion); rupture of amnion in Fallopian tube (tubal pregnancy); hydrosalpinx, hydrops, metrorrhœa intermittens, and hydatiform mole. In regard to the tumor it had to be differentiated from hydrosalpinx, hæmatocele, hæmatoma, pyosalpinx, ovarian tubal and broad ligament cysts and tumors, dermoid tumor, malignant disease and fibroid, the difficulty being relatively greatest in the first enumerated. In arriving at a diagnosis the above conditions were satisfactorily excluded, and due regard was paid to the following points: The tube had been crippled before, leaving it in a favorable condition, as Tait says, to arrest the ovule; it was not patient's habit to have menstruation delayed—it meant impregnation; the tumor had enlarged to an appreciable extent during observation in a limited time.

The diagnosis having been communicated, and the treatment and risks pointed out, I asked the family to satisfy themselves in the opinion by calling in whomsoever they desired. Dr. Bingham, of Waterloo, was accordingly called, and concurred fully in the opinion expressed.

As nine small children were in the home of limited room, I had the patient at once carefully removed to St Joseph's Hospital, Guelph, that

she might get the benefit of the care and nursing that her case demanded. With the assistance of Drs. Robinson and Orton, I opened the abdomen in the middle line, passed the finger into the site of the tumor located in the Fallopian tube, elicited fluctuation and tension almost to bursting, and, much to my concern, found dense, firm adhesions to bowels, pelvic and lower abdominal wall. These were the legacy of the attack of "inflammation" of a dozen years previous. They were separated, tied off, and cut through, as required, with the usual difficulty. During the process, severe hæmorrhage welled up from the bottom of the pelvis, but a diminution of the tension of the tumor announced its source. The bleeding part was clamped, and the enucleation proceeded until sufficiently freed to be tied and cut off. As a considerable hæmorrhage persisted after removal, the field of enucleation was packed with hot sponges, for a few minutes, to arrest capillary oozing. On their removal, however, the bleeding was observed to be active and arterial. It became necessary, therefore, to search out the pedicle and reapply ligatures, which had the desired effect. The condition of the patient forbade any attention to the other tube. The abdomen was irrigated and sponged out, closed, with drainage, and dressings applied. Recovery was uneventful and patient returned home a distance of twenty-seven miles, in two weeks and five days after section.

At time of removal, tumor appeared to be like a short, moderately sized sausage, dark and purple in color. In the interior both fluid and firm lamellated blood was found, also a distinct membrane formation, viz., amnion and chorion, which had undergone detachment from the epithelium of the tube. The tube wall at places was so much attenuated that it appeared ready to burst on slight pressure. That I have been able to restore this mother to the bosom of her home, and save those nine little children from a fate that was mine in early life, has been due, in no small degree, to the ability and painstaking care of Drs. Robinson and Orton, the former of whom conducted the after-treatment for me, and to the efficient nursing of the good and devoted Sisters of St. Joseph.

It may be well to make some observations on the case not treated of previously. Looking back on that attack of inflammation following her second confinement, I think we may be justified in considering it to have been a septic salpingitis, with more or less pelvic peritonitis, which gave rise to the adhesions. If pus formed to any extent in the tube it likely drained out into the uterus, as many cases do; or, if the infection were short of this intensity, it would give rise to desquamation of cilia and epithelia, thickenings, kinking, strictures, and adhesions. It is conceivable that the arrest of the ovule could be brought about by any one or more of these conditions, or even by an interference of the peristalsis of the tube. As to what precisely happened on Sept. 15th, when the severe pain

and gush of fluid occurred, I think we can pretty closely determine: an intra-tubal hæmorrhage, owing to the insecure attachment of the chorionic villi, explains the symptoms quite satisfactorily. The tube being patent at the uterine extremity, the amniotic sac, ruptured from the advancing pressure (of the hæmorrhage), and its contents were expelled. From this time no further development of membranes and ovum would occur. The second attack of severe pain was caused by a recurrence of intratubal hæmorrhage, and the history up to date of operation was that such was still going on. The indication for operation was, therefore, absolute, and the attenuated condition of the tube wall shows that it was performed none too early. Had the patient survived several months longer without the diagnosis being established, I am not so certain that the indications would be so urgent for removal. Her condition as well as the behaviour of the tube would determine that. The case also illustrates quite forcibly that we can never be sure of the existence or characters of adhesions until section, and what may appear to be an inconsiderable operation may prove on opening the abdomen to be most formidable.

Selected Articles.

TRANSLATIONS FROM THE FRENCH.

BY WALTER MCKEOWN, B.A., M.D., M.R.C.S., ENG.

COFFEE IN STRANGULATED HERNIA AND INTESTINAL OBSTRUCTION.

Guérin (*Archives de Médecine*) recommends an infusion of 250 grammes of coffee in 12 cups of boiling water, a cupful to be taken every quarter of an hour, the last four cupfuls at intervals of half an hour. The author cites cases of his own in which this proved successful. Reduction will never be delayed more than four hours. When coffee cannot be given by the stomach it may be given by the rectum, or subcutaneous injection of caffeine may be used.

NEW METHOD OF ADMINISTERING CHLOROFORM.

Preferring in general chloroform to ether, M. Rosenberg finds that the accidents due to chloroform are to be attributed to the manner of administering and not to the drug itself. As every one knows, the danger of chloroform anæsthetic is the arrest of the heart, or of the respiration. Both, he contends, are brought about reflexly by the irritating action of the chloroform upon the terminations of trigeminus distributed to the mucous membrane of the nose. The same reflex can be produced by any other anæsthetic taken through the nose. To obviate this he first renders the mucous membrane of the nose anæsthetic by the use of cocaine, which in itself is an antidote to chloroform. As a result of his experience of this method in fifty cases he concludes as follows :

- (1) The commencement of anæsthesia is less disagreeable for the patient who never makes defensive movements.
- (2) The excitement stage is often wanting, and is always slight except in the case of alcoholics.
- (3) During anæsthesia it is very rarely a patient vomits, and if vomiting does occur there is little retching.
- (4) Upon awakening the patient experiences no disagreeable sensation, and is not haunted by the smell of chloroform or ether.

The following is his routine practice : A few minutes before the general anæsthesia the patient is directed to blow the nose strongly so as to clear the mucous membrane of mucus, and, leaning forward or sitting (never lying down), is directed to snuff into each nostril a centigramme of a powder consisting of some inert substance and 10 per cent. of cocaine hydrochlorate. This is repeated in about three minutes, and general anæsthesia is commenced. If the operation be prolonged the insufflation is repeated at intervals of half an hour. It is also repeated when operation is over, as it causes patient to waken up more rapidly. As to the mode of administering the chloroform itself, the author is strongly in favor of the continuous administration drop by drop.—*Gazette des Hôpitaux, from Berlin Kl. Woch., 1895, No. 10.*

CARBONATE OF COBALT AS A TEST FOR FREE HYDROCHLORIC ACID IN THE GASTRIC JUICE.

Kuratkowski suggests the above as offering the most delicate test for the presence of free hydrochloric acid. He uses the salt freshly prepared, and the test is based upon the fact that free hydrochloric acid, acting upon the carbonate and producing the chloride of cobalt, gives a color reaction, the change being from rose color to blue. He has tried for this reaction with carbonate of cobalt, in the presence of chlorides of mercury of sodium, the per chloride of iron and chloride of ammonium, but always with negative results. Neither lactic acid, butyric acetic peptones, nor acid phosphate of soda, will give this color change. As to its delicacy, the author asserts that it will detect one part in (10) ten million of free hydrochloric acid, which means that it is 500 times more delicate than the phloroglucin vanillin test.

The advantage claimed in addition to its wonderful delicacy is that it is impossible to confound it with any other reaction. The disadvantages are that for each examination it is necessary to prepare fresh cobalt carbonate, and the comparative slowness of the reaction.—*Gazette des Hôpitaux.*

TREATMENT OF HÆMORRHOIDS.

Prof. Roux, notwithstanding the general preference for cutting operations, speaks highly of the following treatment of piles : The patient is placed in the lithotomy position and the two thumbs introduced into the rectum. The thumbs are made to perform semi-circular movements, and separated until they come, by dilatation of the rectum, in contact with the ischium. The piles are thus brought plainly into view. He then takes a hypodermic syringe filled with a fifty per cent. to eighty per cent. solution of carbolized glycerine and injects into each pile two drops of the solution.

The base of the pile should be held between the thumb and index finger, and the needle entered near the anus and pushed through to the base of pile, instead of going directly through the mucous membrane. The object of this is to prevent bleeding, which is, however, only slight. Prof. Roux thinks that the dilatation is principally responsible for the good results, and that the injections are only of secondary importance.—*L'Union Médicale*.

GUAIACOL AS A LOCAL ANÆSTHETIC.

M. Championnière reports (*Gazette des Hôpitaux*) a series of experiments lately made by M. Andro, a Paris physician, on the use of guaiacol as a local anæsthetic. M. Andre, as the result of an accident, received a very painful scald. It occurred to him that guaiacol, like other members of the phenol group, possessed anæsthetic properties, and he accordingly made an ointment containing it for the purpose of applying it to the burn. He was astonished at the relief of pain produced, and determined to try the effect of it subcutaneously. As a result of his experiments he affirms that it will produce effects absolutely identical with those obtained from the use of cocaine.

DIGITALIS AND ITS ALKALOIDS.

M. Franck has made a report to the Paris Academy of Medicine upon the action of digitalis and different digitalins upon the heart. As a result of his experiments he concludes that digitalis acts equally upon the two hearts, and not more strongly on the right heart, as contended by M. Sunor on the left, as the English contend. He also states that an infusion of the leaves of digitalis will produce a more marked action upon the heart than a corresponding dose of digitalin.—*Gazette des Hôpitaux*.

ALCOHOLISM AND ITS PROPHYLAXIS.

The Paris Academy of Medicine has been discussing a great deal during the past summer the subject of alcoholism and its prophylaxis. Elaborate experiments have been made upon animals to prove the poisonous effects of alcohol. This seems to vary with the source of the alcohol, whether from brandy, wine, beer, etc. Also, when injected directly into the blood, its toxic effects are much more marked than when taken by the stomach, comparatively small doses producing death in rabbits when injected subcutaneously. The only conclusion apparently arrived at is, that the old-fashioned way of taking alcohol cannot be improved upon. There will be general agreement with this conclusion.

TWINS AND HEREDITY.

M. Danvin expresses the opinion that the tendency to twin birth is confined to certain families. Gœhlert has furnished proofs of it by statis-

tics. Speyr has given special study to the same question and confirms the statement. It is known that, on an average, there is one twin birth in eighty.

The hereditary tendency to the production of twins is transmitted not only by the twins, but also by the brothers and sisters of the twins.

A difficult thing to explain is that this heredity is transmitted in just about the same proportion by the father as the mother. The feeble vitality of twins is shown by the figures of Gœhlert—only thirty-six per cent. reach the age of twenty. Male twins appear more delicate than female, the average life of the former being seven years and seven months and of the latter ten years. Twins appear to be possessed of feeble powers of procreation, there being one-half more barren unions where one of the parties is a twin than to the average. Speyr shows, finally, that triplets and quadruplets occur nearly always in families which have already produced twins. Miscarriages occur twice as frequently in twin pregnancy.—*Lyon Medical*, August 25, 1895.

PROLONGED RETENTION OF A LIVING FŒTUS BETWEEN THE MEMBRANES AND WALL OF UTERUS.

A young woman whose menses had ceased June 10, 1894, accidentally plunged a long pin into her abdomen five months afterwards. The pin was drawn out without difficulty; but a little while afterwards the waters began to run away and she had an almost continuous bloody oozing. This was thought to be due to a metritis, caused by the penetration of the pin.

A month afterwards the fœtus was expelled. It was then found that the rent in the membranes was exceedingly small, scarcely large enough to pass a five franc piece through, and that the sack itself was very small. It was plain that as a result of the accident the fœtus had passed through the membranes, and had continued to develop between them and the uterine wall.—*Lyon Medical*, Sept. 1, 1895.

SOME THERAPEUTIC (SURGICAL) NOTES.

BY ROSWELL PARK, A.M., M.D.,
Professor of Surgery, University of Buffalo.
BUFFALO, N.Y.

A NEW EXPEDIENT FOR DEALING WITH TOUGH AND INTRACTABLE STRICTURES OF THE URETHRA.

I HAVE recently had to deal with a long-recurring, exceedingly dense, and tough cicatricial contraction of the urethra through which, after tedious effort, I succeeded in passing a filiform whalebone-bougie. Over this, as a guide, I endeavored to pass a variety of urethral instruments, but could coax nothing in the shape of a metallic instrument through the dense tissue. I then opened the deep urethra by perineal section, having the fine whalebone as a guide. Over the slightly bulbous extremity of this filiform bougie I tied tightly a piece of fine, braided silk. Withdrawing this through the urethra in a forward direction, I pulled through with it the silk, which I then proceeded to utilize as a fine chain saw, in the same way that Abbe has succeeded in attacking œsophageal strictures. With the fingers of one hand in the deep perineal opening, and with the other hand free outside, I could pull the silk backward and forward. Using it in this way as a very fine chain-saw, I succeeded in enlarging the canal. After repeated efforts the stricture was divided to a degree permitting a threading of the silk through the eye of a tunneled urethrotome, which was at last passed down through the urethra, its blade separated, and the obstruction divided without further difficulty.

I am quite well aware that the necessity will very rarely arise for adopting this expedient. Indeed, this is the only time that I have ever failed in passing a metallic instrument over a whalebone, when once it had been made to find the passage. Possibly in this instance further manoeuvring would have enabled me to adhere to former practices. So soon, however, as this expedient suggested itself, and was tried, I found that I saved time and accomplished my purpose more speedily, and, consequently, more easily for the patient, than I had feared was possible. The patient's recovery in this instance was uneventful.

A NEW AND IDEAL STYPTIC: A NEW COMPOUND OF ANTIPYRIN AND
TANNIC ACID.

In the *Medical News* of December 15 and 22, 1894, I rehearsed some of my experiences with antipyrin as a styptic in surgical practice, stating that I had for years used a 5 per cent. solution as a spray, sterilizing the water before making the solution. This I had no hesitation in spraying upon any surface, peritoneal, cerebral, or other, from which parenchymatous oozing was taking place to an extent complicating the operation or jeopardizing the success of an ideal dressing. This therapeutic note attracted at least sufficient attention to lead to its pretty general use by surgeons in various parts of the country, from many of whom I have heard commendatory remarks, and from none of whom have I ever heard of disappointment in its use. The present note is to corroborate the favorable esteem in which I have long held this procedure, and to state that I have since resorted to it more widely and more generally for styptic purposes. Thus, I have no hesitation in using it in the urethra, or even in the bladder, in cases of hematuria proceeding from either of these locations. Even in the eye it may be used without fear, preceding its use by that of weak solution of cocaine, though in this location the antipyrin solutions need not be made so strong. On the other hand, it may be used in much larger percentage when the 5 per cent. solution fails to accomplish the purpose; even when small vessels spurt, compression for a few moments with iodoform gauze or acetanilid gauze sopped in this solution will often be effective.

As every physician will realize, there occur cases of bleeding—for instance, from the nasal cavity or from divided bone—in which even these solutions will be ineffective. My present object is to call attention to the combination of antipyrin and tannic acid, in solution, by which there is precipitated an intensely agglutinative and cohesive substance of, to me, unknown chemic composition, which offers the most ideal styptic for certain purposes that I have ever dreamed of. This combination I hit upon by accident and first resorted to in a case of apparently intractable hæmorrhage from removal of adenoid tissue in the vault of the pharynx, in which I was called in consultation by my colleague, Dr. Hinkel. He happened to have at hand a bottle of alcoholic solution of tannin, while I was provided with antipyrin in powder. The case being emergent, I suggested the combination of the two styptics, and added the dry powder to the solution. To our surprise, there was formed at once a gummy mass, at first flocculent, which quickly cohered, the result being a combination the stickiness and adhesiveness of which quite astonished us. A small sponge dipped into the fluid containing this material in suspension was inserted into the postnasal space, and hæmorrhage was instantly checked, not to again recur.

I have since experimented with these materials, and have found that they may be united in almost any proportion with the formation of the gummy mass, and would suggest that the substances be mixed in proportion to the emergency of the case, and to the desire for little or much of the resulting compound. It is possible by adding strong solutions, or by pouring the powder of one into the solution of the other, to precipitate so much of the agglutinative composition as to make a gum that may be placed about the margin of the bleeding bone—for instance, in operations upon the cranium. Or a small piece of sponge or cotton sopped in this material may be forced into a tooth-socket, or in various other ways its use may be made to result in benefit and satisfaction. There is but one attendant difficulty: that is, it is so remarkably cohesive that when the time comes for detachment or separation of the tampon it is difficult to remove it. It may be even necessary to wait for sufficient time for the formation of granulation and separation by natural processes.

I strongly commend to surgeons experimentation with these solutions, and their own determination as to the strength in which it may be best to use them.

MORE WITH REGARD TO MUSTARD AS AN ANTISEPTIC.

In the same issue of the *Medical News* to which I have referred, I endeavored to call attention to the remarkably efficient properties possessed by mustard as an antiseptic or sterilizing agent for the surgeon's hands, and for the skin of the part to be operated upon. One never goes into a house, or at least a locality, in which mustard cannot be easily procured, and my custom is to thoroughly rub and scrub my hands with a mixture of green or other soap, corn-meal, and mustard-flower, using this for about five minutes. After rubbing it thoroughly into all the crevices and creases of the hands and nails by aid of a nail-brush, one may be absolutely certain that his hands are sterilized, no matter what he may have been doing previously. I have no hesitation in proceeding from an autopsy to the operating-room, if I may thus protect my hands. Used as indicated, the mustard leaves no unpleasant sensation; and one may feel that by the time it produces unpleasant tingling or rubefaction of the skin its essential oil has done its desired work as an antiseptic. I have discarded all other means of preparing the hands, and in several years' use of mustard in this way have never been disappointed, nor had the slightest reason to question its effectiveness. I might add also that it is an admirable deodorizing agent, and will take away from the hands all offensive odor of dead or dying tissues, all redolence of iodoform, etc.—*Medical News*.

GEORGE CHEYNE, F.R.S.

DR. CHEYNE was a London physician of considerable eminence and singular character. He was born of a good Scotch family in 1671.

His youthful education was liberal, as young Cheyne was intended by his worthy parents for the church, but their plans being changed, he was placed under the care of the celebrated Dr. Pitcairn, who directed his medical education, and received the degree of "Doctor of Physic."

He is said to have been a very hard student, and to have passed his youth in close application and great abstemiousness. After receiving his medical degree, he removed to London when about thirty years old, and then changed his whole manner of living, partly from inclination and partly from a view to promote his practice. He passed much of his time in free sociability of the young gentlemen of the period, with whom he became "good bottle companions." He soon found that the former temperate and sedate Scottish youth could not keep up the good cheer to which he was treating his unaccustomed system. He began to grow obese, and with the plethora came shortness of breath and extreme exhaustion on the slightest exercise.

His size became enormous, and is said to have reached the enormous weight of 448 pounds.

He abandoned his convivial living, removed to Bath, confined himself to a milk diet, took regular exercise, which reduced his excessive corpulence, and restored his health so that he could ride many miles daily on horseback and attend to a large clientage at Bath in the summer and in London during the winter months. He lived to a mature period, for he died at Bath in his seventy-second year.

Impressed with the value of the treatment he had adopted, he wrote a book urging all people afflicted with chronic maladies to imitate him and try the effects of temperance. At that period most London physicians were, notwithstanding their precepts in favor of moderation, quite given to enjoying the pleasures of the table. Many of them warmly resented Cheyne's endeavors to bring "good living" into disrepute.

Possibly they thought he attacked their interests not less than reflected on their habits, for Dryden wrote :

“ The first physicians of debauch were made,
Excess began, and sloth sustained the trade.”

A Dr. Wynter arose to dispose of Cheyne in a summary fashion. Wynter had two good reasons for hating Cheyne. Wynter was an Englishman and loved wine, Cheyne was a Scotchman and loved milk.

DR. WYNTER TO DR. CHEYNE.

“ Tell me from whom, fat-headed Scot,
Thou didst thy system learn ;
From Hippocrate thou hadst it not,
Nor Celsus, nor Pitcairn.

“ Suppose we own that milk is good,
And say the same of grass ;
The one for babes is only food,
The other for an ass.

“ Doctor, one new prescription try,
(A friend’s advice forgive),
Eat grass, reduce thyself and die,
Thy patients then may live.”

Cheyne responded, with more wit and more good manners, as follows :

DR. CHEYNE TO DR. WYNTER.

“ My system, doctor, is my own,
No tutor I pretend ;
My blunders hurt myself alone,
But yours your dearest Friend.*

“ Were you to milk and straw confined,
Thrice happy might you be ;
Perhaps you might regain your mind,
And from your wit be free.

“ I can’t your kind prescription try,
But heartily forgive ;
'Tis natural you should wish me die,
That you yourself may live.”

Cheyne and a gentleman named Tantley were the stoutest men in Somersetshire. One day, after dinner, the former asked the latter what he was thinking about. “ I was thinking,” answered Tantley, “ how it will be possible to get either you or me into the grave after we die.”

Cheyne retorted : “ Six or eight stout fellows will do the business for me, but you must be taken at twice.”

While Cheyne was the leading physician at Bath, he had many a tilt with Beau Nash, the dictator of the pump room. Once when Nash called the doctor in to prescribe for him, the doctor asked on his next visit if his patient had followed the prescription, when the Beau languidly replied :

* Friend was claimed by Dr. Wynter as his Preceptor.

"No, faith, doctor, I haven't followed it. 'Pon honor, if I had I should have broken my neck, for I threw it out of my bed-room window."

A lady whose fondness for generous living had given her a flushed face and carbuncled nose consulted Dr. Cheyne. Upon surveying herself in the glass she exclaimed, "Where in the name of wonder, doctor, did I get such a nose as this?" "Out of the decanter," replied the doctor.

A patient accompanied by Beau Nash visited Dr. Cheyne for the purpose of ascertaining the cause of a slight abdominal swelling. On examining the patient, the doctor pronounced the swelling to be occasioned by a collection of water, and that it would be necessary that he be tapped. "It cannot be water," said the patient, "It may be wine." "No, no, my good fellow," said Nash, "if it had been wine you would have long before this have tapped it yourself."

Cheyne was a fellow of the College of Physicians at Edinburgh and of the Royal Society.

He was author of the following :

"An Essay on Health and Long Life."

"Tractatus de Infirmorum Sanitate tuenda, Vitaque, producenda," etc.

"An Essay of the true Nature and due Treatment of treating the gout, together with the nature and quality of the Bath Waters, the manner of using them, and the diseases in which they are proper," etc.

"A new theory of acute and slow continued fevers."

"Philosophical Principles of Religion, natural and revealed."

"Fluxionum Methodus inversa: sive Quantitatum fluentium Leges generatiores."

"The English Malady; or a treatise of Nervous Diseases of all Kinds, in three parts."—*J. H. Hunt, in Brooklyn Medical Journal.*

THE ST. JOHN'S AMBULANCE ASSOCIATION.

HIS HONOR THE LIEUTENANT-GOVERNOR OF ONTARIO presided at a meeting held at the Military Institute, November 25, to consider the formation of a branch of the St. John's Ambulance Association for the Province of Ontario. Amongst those present were: Lieut.-Col. Otter, D.A.G.; Lieut.-Cols. Mason, Hamilton, and Davidson; Lieut.-Col. Macdonald, Guelph; Major Mead, Commander Law, Dr. Meyers, Dr. Elliott, Dr. King, Dr. Chas. O'Reilly, Dr. Stuart, and Dr. Ryerson.

This society is the Ambulance Department of the Order of St. John of Jerusalem in England, which has its headquarters at St. John's Gate, Clerkenwell, which is now all that remains of the ancient priory of the order, built in 1504, and recently restored. This order is a revival and a continuation of the old Hospitaller Order of Rhodes and Malta. Its history has been an eventful one, both in England and abroad. It was suppressed in England at the time of the Reformation as a Roman Catholic fraternity, and at Malta when Napoleon took possession of the island. In England, however, it was never annihilated; for after the suppression referred to its members continued in communication with the headquarters at Malta, and, passing through many vicissitudes, continued without state recognition as a fraternity devoted to hospital and charitable work. In 1888 Queen Victoria granted a Royal charter of incorporation, and graciously became its sovereign head and patron, the Prince of Wales at the same time taking the place of Grand Prior. Among the many services which the order has rendered to the public is the establishment of an ambulance society, which has now been formed here. Since the inception of this association in 1877 upwards of 300,000 certificates of proficiency have been awarded, hundreds of detached classes have been formed, one among the police in this city, and over 300 "centres" established. It is spread over the entire Empire, having branches in Australia, South Africa, West Indies, Madras, Bombay, Ceylon, Hong Kong, New Zealand, and at Halifax. Its objects are: The instruction of persons in rendering first aid in cases of accident or sudden illness, and in the transport of the sick and wounded in peace or in war; instruction in the elementary principles and practice of nursing, also of ventilation and sanita-

tion ; the formation of ambulance depots in mines, factories, and railroads ; the organization of ambulance, nursing, and invalid transport corps ; and generally the promotion of works for the relief of the sick and injured in peace and war, independently of class, nationality, and denomination. It should be distinctly understood that its object is not to rival, but to aid, medical men, and with a view of qualifying pupils to adopt such measures as may be advantageous pending the doctor's arrival or during the intervals of his visits. Some idea of its necessity may be learned by the statement that in London alone in ten years 28,071 were injured in the streets, and in England and Wales there are annually lost 2,000 to 3,000 lives by drowning, and in the mines over 1,000.

It was decided to form local centres through the province, as the opportunity may arise, and a local centre will be formed in Toronto at an early date. The formation of these centres is being promoted by Dr. Ryerson, Deputy Surgeon-General, an honorary associate of the Order of St. John. Classes of not more than thirty persons are to be formed, to whom a course of lectures are to be delivered by one of the lecturers of the association. At the conclusion of the course an examination will be held, upon passing which certificates of proficiency will be issued to those entitled to them. On no account will mixed classes be permitted, nor will a lecturer be allowed to examine his own class, so that the certificates may be awarded as an evidence of knowledge apart from any influence which may affect the lecturer.

The following officers were elected: President, his Honor the Lieutenant-Governor; vice-presidents and members of Council, Sir James Grant, K.C.M.G., Ottawa; Senator Gowan, C.M.G., Barrie; Judge Weller, Peterborough; Sheriff Murton, Hamilton; Rev. Canon Richardson, London; Lieut.-Col. Macdonald, Guelph; H. Corby, M.P., Belleville; Judge Hughes, St. Thomas; Dr. R. T. Walken, Q.C., Kingston; Wm. Mulock, M.P., Toronto; Surgeon-General Bergin, M.P., Cornwall; Henry Cawthra, Toronto; W. R. Brock, Toronto; Medical Director, Deputy Surgeon-General G. S. Ryerson, M.L.A., Toronto; lecturers and examiners, Drs. Strange, Grasett, E. E. King, Stuart, Dame, Nattress, Elliott, Myers, W. H. B. Aikens, and O'Reilly; assistant secretary-treasurer, Dr. Campbell Meyers.

Progress of Medicine.

THERAPEUTICS

IN CHARGE OF

GRAHAM CHAMBERS, B.A., M.B. Tor.,

Professor of Analytical Chemistry and Toxicology, Ontario College of Pharmacy; Lecturer
in Organic Chemistry and Toxicology, Woman's Medical College;

AND

WILLIAM LEHMANN, M.B. Tor.,

Physician to the Home for Incurables and House of Providence.

VALUE OF CHLORAL.

It is unfortunate this drug has been so distinctly labelled "hypnotic and sedative," as this action has thrown into the shade the marked power possessed of relaxing spasmodically contracted unstriated muscles and dilating peripheral vessels. These qualities suggest the employment of chloral hydrate in several conditions where hitherto it has been little thought of. Associated with iodide of potassium it is of service in bronchial asthma; and Doctor J. Pal has used it in the form of enemata (fifteen to twenty grains in each) for checking hæmoptysis; here it is assumed to act by the revulsion which it produces in dilating the cutaneous vessels. On the same principle, it is employed by Doctor Cherchevsky, in small doses daily, to counteract the coldness of the feet and hands which is so disagreeable a symptom in certain cases of anæmia, neurasthenia, etc.; he also employs its vaso-dilator function in the treatment of aortic aneurism, where even a dose of two or three grains combined with iodide of potassium assists the action of the latter and keeps up a certain degree of peripheral vascular relaxation.—*The Practitioner* (London).

BAD EFFECTS OF THE TOO FREQUENT STERILIZATION OF THE MURPHY BUTTON.

Dr. Frank Jacob, in *The North American Practitioner*, having recently had the opportunity of using Dr. Murphy's button in an end-to-end anastomosis, and having also had the opportunity of viewing the button *in situ post mortem*, he noticed that the two bowls of the button were not in close enough apposition. The cause of this was due to the weakening of the

spring of the button, as a result of many sterilizations ; as in preparing for a laparotomy he always has a button put in with the other instruments. He would suggest the following to make the button aseptic, in place of sterilization: The button first to be thoroughly washed with soap and water, then boiled in a soda solution, then immersed in a ninety-five-per-cent. carbolic solution for an hour, and kept in alcohol until the time of operation, when, before it is placed *in situ*, it should be rinsed in plain sterilized water.

DEATH FROM ROUX'S SERUM.

At a recent meeting of the Société Médicale des Hôpitaux, M. Mozare read notes of a case in which death resulted from injections of Roux's serum. In the case referred to, the child was not attacked by diphtheria. Other members commented on the serious disturbance which they had observed to follow injections of anti-diphtheric serum. Paralysis had occurred in some cases, also cerebral trouble and diminished urinary secretion, but all the children thus affected were cured. Guinon and Roufflange were the first to report a case of death from injection of serum.—*British Medical Journal*, July 27, 1895.

PAINFUL fissures of the nipples have, for some time past, been treated by the application of cocaine, either in the form of an ointment or a liniment. It has been found, however, that when thus employed the secretion of the milk is diminished, and the erection of the nipple prevented. These objections have led Dr. Joire, of Lille, to use cocaine with the direct object of checking the secretion of milk when necessary. He recommends a solution of one grain of cocaine in ten grains of water and ten grams of glycerine, and he advises that this should be used as a lotion to the nipple five or six times a day. He explains the arrest of secretion by the anæsthesia of the nipple which results.—*The Lancet*.

OBSTETRICS

IN CHARGE OF

ADAM H. WRIGHT, B.A., M.D. Tor.,

Professor of Obstetrics in the University of Toronto; Obstetrician to the Toronto General Hospital.

ASSISTED BY

H. CRAWFORD SCADDING, M.D.,

Physician to Victoria Hospital for Sick Children.

EXCORIATIONS AND FISSURES OF THE NIPPLES.

Dr. Charles Jewitt, in a paper on Preventive Treatment of Mastitis, speaks as follows on the treatment of cracked nipples (*Brooklyn Medical Journal*):

Excoriations and fissures heal in most cases under proper and timely antiseptic treatment. An ointment of equal parts of subnitrate of bismuth and castor oil may be used, as advised by Hirst. The ointment should be frequently sterilized by heat. Before applying, the parts are disinfected. A valuable agent for the latter purpose is the hydrogen dioxide.

Pain during nursing may be relieved to some extent by penciling the nipple five or ten minutes before the child is put to the breast with one to five per cent. cocaine solution. The solution ought to be heated to the sterilizing point shortly before using. A one or two per cent. carbolic lotion applied in the same manner is sometimes useful as an anæsthetic. The addition of one-tenth its volume of glycerine prolongs the action of the lotion and keeps the skin soft.

Deep and painful fissures may be treated with a solid stick of nitrate of silver. The entire raw surface should be touched. The lips of the fissures being well separated, the caustic point is drawn slowly through it. Care must be taken that no excess of moisture is present, otherwise the dissolved silver salt may trickle over the surrounding surfaces and healthy structures be injured. A serious objection to this treatment is the exquisite pain it causes. This may be in a great measure prevented by first numbing the part with a four per cent. cocaine solution. After the application of the caustic the nipple may be covered with a piece of lint, well wet with the anæsthetic lotion. The affected nipple should be rested, if possible, for twenty-four hours or more. Instead of the solid stick, repeated applications of an aqueous solution of the nitrate of silver may be

preferred. In the strength of one or two per cent. it causes little pain and frequently does good service.

In excoriations and fissures that are not too sensitive and do not bleed readily, the nipple shield may be tried. It protects the nipple from the friction, and to some extent from the maceration of suckling. Unfortunately for this method, the child as well as the mother has to be consulted, and the substitute is not always accepted. If artificial nipples are used, it is important that they be rendered aseptic by boiling for five minutes in water immediately before using and not handled with unclean fingers. Similar protection to the nipple lesions is afforded, though in a less degree, by coating the affected surfaces with a pellicle of compound tincture of benzoin. When other measures fail, suspension of nursing for one or two days sometimes succeeds. If both breasts are affected, each may be rested on alternate days. The breast which is not in use should be firmly supported with a compression binder, the nipple being relieved of pressure by the plentiful use of cotton wool beneath the binder.

It is extremely rare that the nipple lesions are so rebellious to well directed treatment as to necessitate the total abandonment of nursing.

A CASE OF ELBOW PRESENTATION.

At 9 a.m., August 20, 1895, I was urgently requested to attend Mrs. R., who was in labor. After considerable questioning, I finally received the information from the midwife and nurse present that Mrs. R. had experienced regular pains for at least two days, and that the bag of waters, exceptionally large, had ruptured about seven hours before my arrival. I then made an examination and found a transverse position of the child, with the head to the left, and an elbow presentation. The shoulder was impacted, the os was very thin, the contraction-ring high up towards the umbilicus, the pains frequent and very severe, and the patient almost pulseless. A part of the amniotic sac hung out of the vulva. The arm that projected was blue, swollen, and edematous.

I could distinguish no foetal heart-sounds.

Having dispatched a messenger for medical assistance, expecting to resort to embryotomy, since version was out of the question, I began the administration of an anæsthetic. Fortunately no physician and embryotomy instruments arrived in response to my note, for during the first stage of anæsthesia the child doubled upon itself in a peculiar manner, and made its exit from the vulvar orifice as if shot from a catapult. The shoulder and back came first, followed by the head pressed against the breach, and, finally, the lower extremities. This occurred about 10 a.m. The placenta was delivered thirty minutes later, and was found intact. Crede's method was resorted to.

Mrs. R. is thirty-eight years of age, and is short and thick set. She has had fourteen children, the last two being still-born. She claimed that in this last confinement she did not expect to be delivered so soon, and insisted with a great deal of emphasis that she felt the foetal movements before the membranes ruptured. She thought that she would bear twins, because she was much larger than usual.

The dead child presented a characteristic appearance. The shoulder that had been extended from the uterine os, as well as the whole arm, was dusky and swollen to three times its usual size, thus giving a beautiful demonstration of the abnormal presentation. The epidermis peeled off very readily.

I attended the woman during the puerperium, and was puzzled at first to account for an extremely rapid pulse, and a rapidly-increasing dyspnoea. Fearing septic infection, although the temperature was practically normal, I gave her brandy, full diet, ergot, and paregoric, to favor contraction of the uterine muscle, and thus close the wide lymphatic channels against the spread of bacterial products; and sodium salicylate, and quinine in large doses. The dyspnoea under this treatment continued to get worse. The pulse did not improve. The patient continually expressed herself as feeling "pretty smart," and did not at all present the appearance of one suffering from a serious puerperal septicæmia.

Rather late in the day, it must be confessed, I examined her heart. I found a weakened and hypertrophied cardiac muscle, and a mitral systolic murmur transmitted into the axilla. Her feet, soon after labor, began to swell. She told me that when she was three months pregnant she complained of pains in her left side and dyspnoea.

I believe, taking everything into consideration, that her trouble dated from the time she began to have the pain in her left side, which, followed by a gradually failing compensation, resulted in a venous stasis, hydramnios, dyspnoea, and, perhaps, in this indirect way, other conditions being favorable, induced the abnormal position of the child, which so seriously complicated the labor.

As soon as diagnosis of failing heart was made, she was put upon digitalis, and is now entirely recovered. The only injury she sustained was a slight perineal tear.—*M. B. Gombert, M.D., in University Medical Magazine.*

MATERNAL IMPRESSIONS.

Dr. Frederick H. S. Ames, of Denver, Col., formerly of Sarnia, Ont., writes as follows to the *Medical Record* :

The case of supernumerary thumbs, recently reported in your columns, recalls a case in which my informant believed that a child was born with

a cleft palate, because the pregnant mother had been surprised at seeing her room mate remove from her mouth a set of artificial teeth.

As counter-evidence allow me to contribute the following: Mrs. S—, who had recently lost an only child, a daughter, aged ten, to whom she had been devotedly attached, and for whom she “mourned, and mourned, and mourned,” became pregnant. Living in the neighborhood was an intimate friend who had an idiot child. During the whole of the pregnancy Mrs. S—was profoundly impressed with the idea that the coming babe would be a girl, and she an idiot; but at the proper time she was delivered of a well-nourished boy, and he as intelligent “as they make them.”

My experience leads me to the following conclusion: If maternal impressions could produce the effect some claim, 1, the majority of conceptions would abort soon after the mother discovered she was pregnant; and, 2, the minority would be “marked” or crippled mentally or physically.

MENORRHAGIA AND METORRHAGIA.

- R. Extracti hydrastis fluidi..... ʒ ss.
 Extracti ergotæ fluidi..... ʒ j.
 Strychninæ sulphatis..... gr. ij.
 Tincturæ ferri chloridi..... ʒ jss.
 Sirupi simplicis..... q. s. ad ʒ viij.
- M. Sig.: ʒ j. t. i. d. after meals.

Medical Record.

ONE HUNDRED AND THIRTY-THREE CASES OF PLACENTA PRÆVIA.

Boss (*Centralbl. f. Gynak.*, No. 35, 1895) collected these cases, which occurred between April, 1884, and April, 1894, in two institutions in Breslau. In one of the hospitals the proportion of placenta prævia to normal labor was 1 in 216, in the other 1 in 42—a remarkable difference. In 27.9 per cent. the placenta was central, in 61.6 lateral, in 10.5 marginal. The percentages of presentations were as follows: head 66.2, breech 1.8, footling 8, and transverse 24. Of the total 133 mothers 8 died—5 from direct effect of loss of blood, and 3 from fever or exhaustion after the first week. Twenty-seven per cent. of the children were born alive. As for management, the tampon, with expectant treatment, was applied in 7 cases, rupture of the membranes with forceps in 9, forced labor in 1, and combined version in 115; in this latter category all the maternal deaths occurred. The cases, however, in which combined version was employed, were all severe. One patient died from air in the veins nine hours after labor.—*British Medical Journal*.

GENITO-URINARY AND RECTAL SURGERY

IN CHARGE OF

EDMUND E. KING, M.D. Tor., L.R.C.P. Lond.,

Surgeon to St. Michael's Hospital; Physician to House of Providence and Home for Incurables; Pathologist, Toronto General Hospital.

EPIDIDYMITIS AND ORCHITIS.

Dr. James P. Tuttle, in an article on "A New Treatment for Epididymites and Orchitis," in the *Journal of Cutaneous and Genito-Urinary Diseases*, after reviewing the different forms of the disease—those due to gonorrhoea, prostatitis, vesiculites, and cystitis, and the general systemic consequences of these, refers to the many treatments that have been adopted and rejected as not meeting the symptoms. He relates his personal experience with a new line of treatment adopted by him, and cites several cases with histories to corroborate the statement. He applies guaiacol locally along the upper part of the cord and scrotum, to reduce the local pain and accompanying high temperature. This application is not repeated for thirty-six hours, and merely has to be done the second time. The pain is usually relieved within two hours. After the guaiacol has been applied, the scrotum is left exposed for half an hour and elevated on a support resting between the thighs. This is then covered with a piece of flannel wet in hot water, and laid over this an ordinary water bottle filled with water as hot as the patient can bear, and from the pressure of the same good results follow. The hot application is kept up until bedtime, when the patient is directed to apply an ointment of 25% ichthyol in lanolin. Surround the scrotum with rubber protective tissue, and support the testicles by suspensory or other means. After the subsidence of the pain the hot applications are continued for a few days, and small doses of iodide of potassium given to promote the absorption of the induration. He opposed the strapping and compression of the swollen organ as a method of treatment. He does not claim better results as far as final issue is concerned, but does claim a more immediate relief of pain and a proportionate absence of untoward symptoms. He warns against painting the guaiacol on the lower portion of the scrotum or any part of the rectal tissue, on account of the excoriations. He also warns against using any but pure guaiacol.

IRRIGATION IN GONORRHOEA.

DR. CHARLES E. CUMSTON in an article on the treatment of gonorrhœa in the male by urethral irrigation of permanganate of potassium, in the *Journal of Cutaneous and Genito-Urinary Diseases*, says that during the past two years the results have been so excellent that he is anxious to introduce the treatment more generally. The irrigation by permanganate of potash was first advocated by Dr. Pierre Janet, of Paris, but the author's technique differs somewhat. He describes the method as follows: A conical, full soft rubber catheter (Parker's sound), perforated by three pin point holes at the base of the cone, giving a recurrent flow, a glass irrigator to which is attached five feet of rubber tubing, is all the apparatus required. The irrigator holds one litre—a sufficient quantity for one irrigation. The solution is always $\frac{1}{30000}$; the pain is only slight, and absent after the first and second irrigation. To be used once daily, and the average number fifteen. The urethra is washing out while the sound is being introduced, by allowing the flow to begin as soon as the sound is an inch in the urethra. The author makes continuous slide-examinations for the gonococcus. He concludes:

- (1) The average duration of the affection is fifteen days.
- (2) Complication, such as egotite, orclulu, epedegnuli, artheitis, or bubo are very infrequent. Chordee is less frequent under this treatment, although some of his cases suffered from it.
- (3) Ardor urinæ only lasts at most four days—usually only two.
- (4) That gleet is infrequent if treatment has been properly carried out.

 CYSTITIS AND INFECTION OF THE URINARY TRACT.

A most exhaustive and interesting monograph, by Dr. Max Melchior, on cystitis and infection of the urinary tract, has just been translated into French. Professor Guyon thought so well of it that he wrote a very eulogistic preface. It is to be hoped that it will soon be translated into English.

In reference to treatment, the author pins his faith to nitrate of silver washings, in strength varying from 1-500 to 1-200 after each washing, and allowing the silver solution to remain five minutes in the bladder. It is then irrigated with a solution of boric acid. The following are the conclusions arrived at:

- (1) Cystitis is due to microbes, excepting the few cases of chemical irritation. Usually there is found in the urine a pure culture, very abundant. The colon bacillus is the one commonly encountered. It is pyogenic, but its virulence varies greatly. In the urethra and the vagina pathogenic microbes are frequently found. If introduced into the bladder

they may cause cystitis. Microbes alone are not able to cause cystitis. The proteus of Hauser, if introduced into the bladder in virtue of its strong decomposing action on the urea, sets up inflammation. There is usually required, however, bladder congestion, the most frequent causes of which are retention or traumatism. These factors, however, are merely predisposing, the microbe being the exciting cause.

(2) The different degrees of cystitis depend upon pre-existing lesions, the quantity of the nutritive material, and the special characteristics of bacteria, especially their virulence. The existence of catarrhal cystitis is doubtful, though, possibly, non-pyogenic microbes in the cellular tissue may provoke suppuration.

(3) Ammonuria is often an insignificant phenomena occurring in the course of cystitis—often is entirely absent. Aside from the tubercle bacillus, there is an acid cystitis caused by the colon bacillus, the pyogenes streptococcus, and the more rare micro-organisms, the gonococcus and the typhoid bacillus. If urine, taken with antiseptic precautions, does not yield cultures upon appropriate media, there is a probability of tuberculous infection. There is a true gonorrhœal cystitis due to the gonococcus of Neisser. Urinary fever is due in part to the absorption of the urinary microbes into the blood, particularly, and certainly most frequently to the absorption of bacterial toxines. To avoid producing cystitis it is not sufficient to sterilize the urethral orifice. The whole urethra must be irrigated with boric acid, otherwise a sterile instrument is at once infected.

PÆDIATRICS AND ORTHOPÆDICS

IN CHARGE OF

W. B. THISTLE, M.D., L.R.C.P. Lond.,

Assistant Demonstrator of Anatomy, University of Toronto; Physician to Victoria Hospital for Sick Children; Clinical Lecturer on Diseases of Children in the Woman's Medical College;

AND

B. E. McKENZIE, B.A., M.D.,

Lecturer on Orthopædics and on Surgical Anatomy in the Woman's Medical College, and Surgeon to the Victoria Hospital for Sick Children, Toronto.

RICKETS.

The essence of rickets being a failure to assimilate the earthy salts, its principal manifestations are found in the nervous and osseous tissues. The nervous disturbances may be so slight as to elicit little attention, or may be misinterpreted. The comparative rarity of rickets in this country is apt to throw us off our guard, and many cases of this disease run their course under the name of gastro-enteritis, intestinal indigestion, intestinal catarrh, etc. It is not uncommon for a rachitic child to appear vigorous and robust during the first two or three months of life, and even to take on an excessive amount of fat. It will usually, however, show indications of indigestion, especially in the intestinal tract. There may be constipation or diarrhœa, more frequently the former at first. Attacks of severe colic are not uncommon. The abdomen is tumid. They are poor sleepers, having restless nights. These manifestations appear especially in bottle-fed infants. There may be no further symptoms for three or four months. Retarded dentition may be the first circumstance to call attention to the probable character of the disturbance. As nutrition of the brain becomes more impaired, nervous irritability increases. There is fretfulness, restlessness, tossing, rolling of the head, and loss of interest in surrounding objects. Convulsions are not uncommon. Tetany is of frequent occurrence. One of the most characteristic of the convulsive manifestations is spasm of the larynx, known as laryngismus stridulus.

Implication of the vasomotor nerves is indicated by enlargement of the arteries, of the veins of the head and neck, and profuse sweating of the head, especially during sleep. To the same cause may be assigned bronchial catarrh. There may be general hyperæsthesia, tenderness in the

joints producing pain on motion, the child preferring to lie undisturbed upon the back, and caring little to be amused. It is probable that there is an actual paresis, in many cases due simply to nerve starvation.

Following these conditions are trophic changes in the bones. One of the earliest is cranio-tabes, consisting in defective and irregular develop-



ment from the various centres of ossification of the skull, and perhaps even of absorption of bone cells. There is undue patency of the fontanelles and sutures, and irregular depressions in the occipital region. The sensation conveyed to the finger is that of the existence of small oval hollows or soft supports in the occiput. The head is not unusually large,

unless hydrocephalus be present, but is apt to be long, and the forehead prominent and the sides bulging. Dentition is often delayed. The teeth are widely separated, and are frequently notched. There is enlargement of the epiphyses, and softening of the shafts of the long bone. The wrists and ankles are large and bulbous, and the yielding shaft often gives rise to curvature in the limbs. The ribs are among the first of the long bones to show these changes, and we have a "beaded" chest. As a consequence of the foregoing conditions we have bow-legs, knock-knee, flat-foot, the various spinal deviations, pelvic irregularities, and thoracic distortions.

When the characteristic bone-changes have developed, diagnosis is easy; but in the early months of the affection, when it is most amenable to treatment, it often escapes recognition. Especially is it common in artificially nourished infants. In its incipiency it is frequently treated as a gastro-enteric disorder, just as spinal caries has often been, owing to the initial gastralgia. The most important diagnostic symptoms are profuse sweating of the head, abnormally large secretion of urine, copious phosphatic deposits, and hyperæsthesia. The disease may be mistaken for Pott's disease, true lateral curvature, congenital syphilis, and acute rheumatism.

Not until deformity appears as a result of the constitutional taint, either in the form of curvatures of the spine, deviations of the long bones as seen in bow-legs, knock-knees, and other distortions, is the patient brought for surgical relief. It is only by the earliest recognition of the symptoms and in the appreciation of their importance that prevention can be accomplished. In the earlier stages these cases necessarily come under the care of the general practitioner, and if remedies are employed with a view to correcting the malnutrition, much would have been done to prevent deformity. As means of constitutional treatment, massage, phosphorus, cod-liver oil, iron, hold an important place. Proper feeding, bathing, and general hygiene are of the first importance, and of greater value than medicinal treatment. Change of air is often one of the best means to be employed.

For the correction of these deformities,

- (1) Mechanical appliances,
- (2) Manual immediate rectification,
- (3) Osteotomy,
- (4) Osteoclasts,

may be employed. Mechanical measures are effective in bow-legs before sclerosis has occurred; also in knock-knee and the opposite condition before great rigidity results.

Forcible manual straightening can be employed in moderate grades of

deformity, and injury to the hard and soft parts can be regulated with accuracy. Force must be applied suddenly, while due care of the epiphysis is observed. This is possible only in young children. Care must be taken not to separate the epiphysis, as it is likely to interfere with growth of length of the limb. The best dressings after over-correction of the deformity is plaster of Paris.

Ostonotomy is the best operation for correcting these deformities. Clean, sharp, effective, the osteotome is a most valuable instrument. MacEwen's instrument is probably the best. The operation is practically subcutaneous, and may be treated as a simple fracture. When thorough asepsis is observed, suppuration is almost unknown. Drainage is seldom necessary, and the removal of a wedge-shaped piece of bone is seldom required. The gap which is left in straightening the limb soon fills up with callus, and a strong and straight limb results. In knock-knee and the opposite condition MacEwen's operation above the epiphysis of the femur is the best. Osteotomy of the head of the tibia and fⁱfibilæ is apt to produce free bleeding, and is seldom required.

Osteclasis is largely employed in France, and by a few operators in America, but there is little to recommend it in preference to the means just described. The deep tissues may be much injured, and there is uncertainty as to where the fracture will occur.—*From Ketch, Lee, and De Forest Willard in Vol. VII., Trans. Amer. Orthopædic Association.*

The foregoing cut is from a photograph of a Canadian child, and is such an exaggerated case as one seldom sees in this country.
—B.E.M.]

BACTERIOLOGY

IN CHARGE OF

JOHN J. MACKENZIE, B.A.,

Bacteriologist to the Provincial Board of Health.

ASSISTED BY

HIBBERT HILL, M.B.

Bacteriological Laboratory of the University Medical Faculty.

THE VIRULENCE OF BACILLUS COLI COMMUNIS.

De Klecki has just published the results of some interesting experiments upon the virulence of bacillus coli in peritonitis due to intestinal obstruction, artificially produced in animals. His results are summarized as follows :

This form of peritonitis is, as a rule, a poly-infection due to the invasion of different species of bacteria, present in the intestine, into the peritoneal cavity. The majority of these forms do not present any special virulence, others are virulent. The virulence of bacillus coli is acquired under pathological conditions, and is due, in part at least, to symbiosis with other species, a symbiosis which becomes very intimate on account of the enormous multiplication of bacteria in the pathological intestine.

The exaltation of virulence is acquired, not after passage into the peritoneal cavity, but in the lumen of the intestine itself.

The contents of a strangulated loop is an excessively pathogenic substance, and it is the resorption of this which gives rise to the general symptoms in grave cases.

By the resorption of these contents, the peritoneum, taking part in the general condition of the organism, is rendered less resistant to infection than in the normal state.

As it is possible to provoke a peritonitis by the action of the toxin of a virulent colon bacillus, a peritonitis which is only a symptom of the general intoxication, so it is only as a result of the intoxication of the organism with the contents of the pathological intestine that there is produced an aseptic peritonitis which is transformed into a septic peritonitis after the passage of the intestinal bacteria into the peritoneal cavity.

There are present in the contents of a strangulated intestine several pathogenic microbes : the colon bacillus is then not the only pathogenic

agent in the disease. The same result may be reached by comparing the activity of the contents of the pathological intestine *in toto* with that of the colon bacillus or the other species present ; the former is always most pathogenic.

As to the passage of the bacteria through the walls of a strangulated loop, De Klecki has found that it takes place in a different manner, according to the pathological condition of the tissue. When the intestinal wall is more or less necrosed, the bacteria are seen in all parts of the wall.

When there is only a pronounced venous stasis, the bacteria are found in the mucosa, but especially in the submucosa, where they are very numerous in the vessels, in a free state or enclosed in cells ; in the tissue of the muscular coat, they are rare ; in the subserous tissue they are very numerous in the interior of the vessels.

De Klecki concludes that, under these conditions, the passage of the bacteria outwards is not direct, but by means of the blood vessels of the intestinal wall.

The muscular coat appears to offer the most resistance to the passage outwards.—*Annales de l'Institute Pasteur*, September, 1895.

HYGIENE AND PUBLIC HEALTH

IN CHARGE OF

WILLIAM OLDRIGHT, M.A., M.D., Tor.,

Professor of Hygiene in the University of Toronto ; Surgeon to St. Michael's Hospital ;

AND

E. HERBERT ADAMS, M.D., D.D.S.

NATIONAL CONSUMPTIVE SANITARIUM.

The by-law for the granting of a subsidy of \$10,000 to the proposed consumptive sanitarium in Gravenhurst, Muskoka, has been carried with the greatest enthusiasm by over 97 per cent of the votes cast.

PHYSICIANS in Arkansas who become inebriates are debarred from practice by having their license revoked by the state board of health.

THE CAUSES OF DEATH.

According to the census of 1890, of every 10,000 deaths in the United States one will be from calculus, 35 due to Bright's disease, 40 to fevers other than typhoid, 59 to rheumatism, 70 to scrofula, 130 to cancer, 140 to apoplexy, 148 to whooping cough, 160 to dysentery, 190 to meningitis, 220 to scarlatina, 246 to ague, 250 to convulsions, 310 to typhoid fever, 350 to heart trouble, 480 to diphtheria, 880 to diarrhoea, and 1,420 to phthisis. Of this number 2,210 are from typhoid, diphtheria and phthisis, all of which are preventable, and if we take in whooping cough, dysentery, scarlet fever and diarrhoea, we shall have more than one-third of all deaths at the present time from preventable causes.

DISINTERMENT of the dead is prohibited by an act of the late Ohio legislature, between April and October of each year, and altogether in cases of death from infectious disease.

ALCOHOL IN MEDICAL PRACTICE.

From the London *Lancet* is derived a statement of comparative mortality in the London hospitals for 1894. The Temperance Hospital had the smallest death rate of all: 5.6 per cent., against more than double

that rate (11.6) in others. Taking the average of all the general hospitals, and excluding the cases where mere temporary relief was afforded, the Temperance Hospital exceeded all in the percentage of cures, as 67.1 to 54.4. Sir B. W. Richardson said that during his connection with the London Temperance Hospital he had treated upwards of 1,000 cases of acute disease, without having recourse to alcohol.

THE Home for Consumptives at Denver, which has been erected by Mrs. W. D. Sloane and Mrs. Auchmuty and others, at a cost of \$150,000, was opened in last October. The home is simply a sanitarium, not a hospital. Only incipient cases are taken. There are to be no nurses and no resident physician, and inmates will provide for themselves in these respects. They will do well, also, to find out for themselves before going there whether their cases are adapted to profit or to suffer by the high atmosphere of Denver.

SENILE HEART.

Four cardinal rules with regard to diet : (1) There must never be less than five hours between meals. (2) No solid food is ever to be taken between meals. (3) All those with weak hearts should have their principal meal in the middle of the day. (4) All those with weak hearts should have their meals as dry as possible.—*Balfour*.

SHELLED EGGS.

A consular report tells of large quantities of shelled eggs being sent to England from Russia and Italy for the use of pastry cooks, bakers, hotels, and restaurants, says the *Philadelphia Press*. The eggs are emptied from their shells into tin cans holding 1,000 or more, and, after being hermetically sealed, are packed with straw into wooden cases, the taps through which the contents are drawn being added by those using them. Great care is necessary in selecting eggs, as a single bad one would spoil the whole lot. Lower price and saving of time, and greater ease and less expense and loss in handling, are named as the advantages of this system. Thus far the Russian product has been uniformly good, whereas the Italian shipments have so frequently been spoiled that analysis of the Russian supply has been ordered to determine if preservatives are used.

A NEW SANITARY MEASURE.

There can be no doubt that communities and corporations are responsible, both morally and legally, to those who are harmed by their negligence of well established sanitary laws. In pursuance of this application

of a settled principle of the common law, the widow of a workingman who died of typhoid fever last year in Ashland, Wis., has brought suit against the Ashland Water Company for \$5,000 damages, alleging that the corporation permitted its water to become polluted by typhoid germs, and that her husband's death was due to this pollution. If the facts alleged can be established by evidence, there seems to be no reason why the wronged woman may not recover the small compensation demanded for the loss of her husband through the company's neglect of amply patent as well as patented means to keep its water purified. Once a precedent like this shall be established, there will be no lack of suits and recovered damages to awaken the sordid constituencies of municipal and water corporations to their responsibility for the avoidable creation and diffusion of pestilence, and to the *quod est demonstrandum* that it would cost them less money to stop it.

ARTIFICES EMPLOYED BY FEMALES.

M. Verchère (*La France Médicale*, August 30th) says that the use of the catheter within the cavity of the uterus has become comparatively free from danger; so far as regards infection, its use among gynæcologists has become far too general. It is now used for all kinds of purposes, whether with or without necessity matters little. The consequence is that women are aware of its frequent use and comparative safety, and too often designedly lead the physician to bring on an abortion when he has no intention of doing it, and he may never know that he has been the unsuspecting cause.

If the use of the catheter in the womb in very rare and exceptional cases may seem necessary, it should not be applied until the practitioner has frequently examined the patient and verified for *himself* the existence of the catamenia. It is during the four or five days that follow the menses that he can be justified in resorting to that operation, and only under such circumstances is he free from the danger that an operation, apparently very simple in itself, and very innocent, may cause serious injury to the embryo, but it might lead to results which would prove dangerous to the woman and seriously implicate the operator.

Uterine catheterization has produced innumerable abortions that are never known even to the operator, and are never suspected by the world—more than would seem credible—while the cases in which it may be of use are comparatively few. For these reasons, he says, "I cannot too earnestly protest against an abuse which is at present too common, and I would be glad to see it laid aside entirely by prudent and conscientious practitioners as a means of exploring generally useless and always dangerous, for the exceptions are very few."

Editorials.

THE SANITARIUM FOR CONSUMPTIVES.

WE are glad that we are likely to have this much needed sanitarium in the near future. The site selected for the institution is situated about one mile from the town of Gravenhurst, on the shore of a pretty bay of Lake Muskoka, and is surrounded on three sides by dense forest, which will prove an effective wind-break in winter. Mr. Dwight, of Toronto, in a letter to the *Daily Mail and Empire*, speaks very highly of the location. He states that for thirty years he has visited the district once or twice a year, and, during the same period, he frequently visited the Adirondacks. His personal observation of these two districts leads him to believe that the choice of Gravenhurst as a location was a wise one. We hope that Messrs. Gage, Massey, and others who are taking an interest in the establishment of the sanitarium will receive the support they deserve in their undertaking.

MATRICULATION IN MEDICINE IN ONTARIO.

THE regulations of the Ontario Medical Council concerning matriculation, as carried out since the June meeting, have caused a good deal of dissatisfaction, as well as serious inconvenience, to some intending students. The council requires one specific departmental certificate, and entirely ignores equivalents. For instance, a young man may have matriculated in the University of Toronto, may have attended lectures in arts for three years, may have passed the regular examinations required at the end of each of the first, second, and third years; yet he would not be accepted as a matriculant by the council, because he has not the necessary specific certificate.

It has unfortunately happened that certain young men, who could ill afford the delay, have lost a whole year through regulations which have been sprung upon them with insufficient warning, although they were well qualified to commence the study of medicine. We feel certain the major-

ity of the members of the council do not wish to do such injustice. They desire a high standard, and rightly so, but surely they do not want to hurry and worry intending students by rules and regulations which even the Registrar can scarcely understand. Dr. Pyne's ability and courtesies are unquestioned, but he is, of course, compelled to carry out the regulations as prescribed. We hope the Education Committee will carefully consider the whole question at its next session, and, at the same time, keep in view the desirability of having a uniform standard of matriculation for the whole Dominion. That would be one of the most important steps towards uniformity in the whole curriculum in the different provinces, and a system of reciprocity or Dominion registration.

THE BRITISH ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.

THIS association will meet in Toronto in 1897. The central committee has already done much work in the way of making arrangements for the meeting. The following sums of money have been promised: \$10,000 from the Dominion Government, \$7,500 from the Ontario Government, \$5,000 from the City of Toronto. The majority of the committee think the Dominion Government should give a larger amount, and are trying to obtain a promise of a larger amount. Circular letters have been sent to the Premiers of the various provinces of the Dominion asking them to co-operate with the committee. Most of these have sent favorable replies. The association has only held one meeting in Canada, *i.e.*, the meeting of 1884 in Montreal. The meeting of the Canadian Medical Association was held in Montreal at the same time, and the regular attendance of many members of the British Association added much to the interest of our Dominion meeting. It is expected that the Ninety-seven meeting of the Canadian Association will be held in Toronto while the "Britishers" are with us.

THE DINNERS OF THE MEDICAL COLLEGES OF TORONTO.

THE banquets of the Toronto and Trinity Medical Colleges this year were highly successful. There is, of course, nothing new or startling about the statement, as it is practically a repetition of the old story we have told for many years. The medical students' dinner in Toronto is always so far ahead of any other event of the kind that anything like

comparison is needless. In looking back on these banquets for, say, fifteen years, one can recognize the fact that a marked improvement has taken place in many ways. And yet, fifteen years ago they were considered so successful that anything much better was thought impossible. From the students' point of view the annual dinner is one of the two great events of the year—the second being the examination. The boys, as a rule, prepare equally well for both; but the dinner they love better than the other event. Never did they show greater enthusiasm than they manifested this year.

We publish in this issue the able address of Mr. B. G. Connolly (class '96), the chairman of the banquet of the Medical Faculty of the University of Toronto. We regret that we have not sufficient space for the other speeches delivered by the various students, as they were all admirable in character. In a general way, it may be said that to the students is due nearly all the credit for the success of the banquet. They are wise in choosing as their honorary chairman a member of the faculty, and thereby keeping themselves closely in touch with the college authorities. We desire to congratulate the honorary chairman, the chairman, the other members of the committee, and the body of students, upon the pronounced success of what the vice-chancellor correctly called the finest educational banquet ever held in Toronto.

ADMINISTRATION OF ANÆSTHETICS.

IN the hope that some measures may be instituted to correct the present need, it is desired to emphasize the great lack of instruction which obtains in the medical schools and hospitals of this city, if not in this country, in that most important branch of medical practice, the administration of anæsthetics.

Is it possible for the pupil to gain any proficiency in the art of giving an anæsthetic from merely observing a house surgeon administer the drug? Or is it likely he will even take the slightest notice of the anæsthetic when there is an interesting operation in progress? We do not mean to cast the slightest reflection upon the methods of our house surgeons in regard to this part of their duty, but we dare say that it is not till even these have been some years in practice that they begin to appreciate the value of the opportunities for actual administration which their residence in a hospital has afforded them. Is it not true that the vast majority of our students are given the authority to practise medicine, surgery, and midwifery, without having once administered ether, chloroform, or nitrous oxide gas? They are taught the doses of strychnia, arsenic, morphia, etc., but who can

tell them accurately the lethal dose of chloroform by inhalation in any given case? They are told that there is danger from an overdose, and with equal truth, just as great, if not greater, danger, from the exhibition of too small a quantity. While in the majority of cases the experienced anæsthetist recognizes certain danger signals, and is able to arrest many a catastrophe, yet even he may be surprised by a chloroform accident, which may arise with almost incredible rapidity. These signals and alarming casualties cannot be duly appreciated by any who have not closely observed a large number of cases in every stage of anæsthesia artificially produced.

Dr. Hewett says: "It thus happens that numerous recently qualified practitioners leave their hospitals possessing but the scantiest knowledge of the subject, and owing to the bewildering mass of literature which exists, and to the difficulty of extracting any really practical information from it, they regard all further attempts at self-instruction as hopeless, and resort to the simplest rather than the safest plans of anæsthetizing their patients."

"Ether is the anæsthetic which should be chosen, as a general rule, for all operations which cannot be satisfactorily performed under nitrous oxide. It should be the routine anæsthetic for general surgical work."

This is manifestly not as it should be, and until some course of systematic instruction is instituted in our school and hospitals it surely is the duty of all surgeons and professors of *Materia Medica*, and medical men in general, who have to do with the training of students, to advise the use of the safest pain-destroying agent. There are certain operations for which nitrous oxide, or nitrous oxide combined with oxygen, answers admirably.

For example, minor operations which may be rapidly performed include most operations for tooth extraction. In dental operations where prolonged anæsthesia is required, the rule which governs the administration for general surgical work should be followed. Chloroform should not be given to a patient in the dentist's chair. In some cases it becomes necessary, by reason of the nature of the operations, to administer chloroform, *e.g.*, excision of jaws and tongue, repair of harelip, cleft palate, removal of tonsils, nasal growths, etc. Patients suffering from emphysema, chronic bronchitis, and some forms of heart disease, are more easily and safely anæsthetized with the a.c.e. mixture.

Meetings of Medical Societies.

TORONTO MEDICAL SOCIETY.

THE regular meeting was held in the Medical Council Chambers, November 14th, the President, Dr. Oldright in the chair.

Dr. W. J. Wilson presented a tapeworm which was tied in two knots, passed by a little girl three years of age. The patient had given a history of eating raw meat. The anthelmintic used was pumpkin seeds, which were advised on account of the age of the child. In adults he had found the best results from the use of thymol, given in twelve grain doses every fifteen minutes until two drams were taken. A dose of castor oil should be administered the preceding night, and the patient should refrain from taking supper or breakfast. About twenty minutes after the last dose a purgative is given. If the thymol depresses the circulation whisky may be administered concurrently.

Dr. Oldright said he had used pumpkin seeds a good deal. One method of preparing them was to take a half a pound of the seeds and bruise in a mortar; add one quart of water and allow them to macerate all night; then strain; then add enough water to make a pint; and give after fasting. Two hours after an active purgative should be given.

Dr. Carveth said that he had never seen any bad effects from tapeworm. He did not think they did any harm except in causing the patient mental worry.

Dr. McMahon said he had found patients complain of pain, which might have been due to gastralgia.

Dr. Oakley said he was consulted a few years ago by a woman who had been under treatment for a considerable time for consumption. He found out accidentally that she had passed portions of tapeworm. He administered malefern. She became stout and rugged.

Dr. Wilson then presented a paper on

VENUS CONGESTION OF THE FEMALE PELVIC ORGANS.

It was to be remembered that these organs contain lymphatic arteries and veins. In studying this form of trouble, their position,

structure, and function, were also to be kept in mind. In some cases their engorgement was of a secondary nature, the result of the pressure of a new growth which, when removed, relieved the condition. Physiological engorgement occurred during the menstrual period. Women usually kept on their feet during this period, when their strength was not equal to the task, suffering and struggling on as best they could. He believed this was one of the reasons that the condition was so often found among teachers and shop girls. It was often observed that girls of this class frequently became weakened so that they were not able to undergo fatigue. Other causes of the condition were exposure to cold during the menstrual period, constipation, and straining at the stool. A weak heart strongly disposed to the condition, also the absence of valves in these veins. The dependency of the parts in relation to the heart aggravated the condition. Another frequent cause was too early getting up after labor, the usual time being in most cases nine or ten days. It was to be remembered that it took six or eight weeks for the uterus to return to its normal size and condition. Miscarriages were another fruitful cause, especially in the early months of pregnancy. The condition was often associated with prolapse, flexions, versions, and other diseases of this region, which required to be looked for and treated first.

CASE I.—Mrs. G., aged twenty-eight, tall and slight, never very strong, but always healthy, was delivered eighteen months previous to consultation. Was not taken care of after confinement, and got up too soon. Complained of weight in the back and the pelvis. Had a leucorrhœal discharge, and was constipated. Examination showed retroflexion and tenderness at the point of flexion. The os was soft and large. The mucous membrane was abraded and bathed in a leucorrhœal discharge. Ovaries slightly enlarged and tender. Had been under treatment since confinement. After three months' treatment was cured of all but the flexion. The pains were gone and she was able to resume her duties.

The most common symptom in these cases is that of weight in the pelvis and pain in the back. The veins of the vaginal plexus are seen to be enlarged. Associated with this there may be hæmorrhoids and a varicose condition of the veins in the legs. This condition cannot be recognized any more by the finger than piles. To diagnose, the symptoms must be depended on together with the general state of the patient's vascular system. The patients generally felt better in the morning, especially if the hips were raised during the night to favor the circulation from the parts. Where this varicose condition exists there may be sudden and severe hæmorrhage internally. Christine Neilsson, the singer, died from rupture of a vein of the ovarian plexus. The treatment of this condition is both local and general. The general health must be toned up, and if any weakness

of the heart exists special attention should be given to it. The diet should be regulated. Sponges with cold water, and frictions followed by douches, if the patient can stand them, will generally give relief. The recumbent position should be assumed once or twice during the day and oftener during the menstrual period. Special precaution after labor should be observed by those who have previously suffered from pelvic diseases. A prolonged stay in bed for three or four weeks may afford a cure of the condition. For the bowels, salts answer very well, making a valuable laxative, and deplete to some extent the hæmorrhoidal plexus. Where there is much pain and discomfort, bromide of potash, quinine, and Jamaica dogwood may be administered. The medicines to be relied on most were hamamelis and hydrastis.

CASE II.—Mrs. C., thirty years old, florid, with sluggish circulation and a tendency to venous congestion. Had a small ulcer in the rectum one inch in diameter. In the centre of the ulcer were two little points which bled freely. Hæmorrhage almost daily for months. She was given hamamelis and hydrastis three or four times a day, and the hæmorrhage was rapidly controlled. She said she could feel good results from a single dose.

Locally hot douches were useful, remembering the effect of hot water in shrinking the hands of a washerwoman. Also astringent suppositories and tampons saturated with astringents and antiseptics could be used.

Dr. McMahon said he had not much faith in hydrastis and hamamelis; he thought ergot did harm in certain cases—hæmorrhage of the lungs for instance. About the only drug he found of use in such cases was morphine.

Dr. Macdonald said there was no doubt women attempted to get up too soon after labor. It had been his practice for years to ask his patients to remain in bed two weeks after confinement, and even after that to lie down for a portion of the day. He also favored the use of purgatives; for with many women there was a tendency to become constipated. He favored the use of magnesia sulphate. The other remedies which improve the general condition of the patient, such as massage and exercise, were to be recommended. He did not find much good from the administration of internal remedies. He had seen hamamelis and hydrastis do good in some cases. In regard to local treatment, it was often found that the interior of the uterus was in a granular condition. If so curettement and tamponage with iodoform gauze were helpful, more especially if there was a tendency to bleeding. If curetting were attempted it should be done thoroughly and under the strictest antiseptic precautions; otherwise it was dangerous. After curettement applications of Churchill's iodine might be made. If packing were resorted to the vagina might be plugged as well; and the packing might be removed from it in twenty-four hours; that in

the uterus might remain six days if necessary. Boro-glyceride tampons with tincture of belladonna would give benefit. About twenty minims of fluid extract of belladonna was sufficient to alleviate the pain. The doctor also referred to the benefits of electricity.

Dr. Carveth said he found fault with the construction of the average bed. It would be found that in most beds the hips would be from six to twenty inches below the head which was an unnatural position. If a newborn babe were examined it would be found that the most comfortable position was where the head was lower than the hips.

Dr. Starr pointed out that the curves of the spine were different in adults from those in children ; so that the position natural to a child was not to an adult.

Dr. Hamilton accounted for many of these pelvic and rectal congestions by the inactivity of the liver. Many inflammations, he stated, were due to blood stagnation, cathartics, massage, and frictions would give great relief. Surgical treatment of these cases did not remove the causes.

Dr. H. Walker found that these troubles occurred less among factory girls than among women of sedentary habits of the better classes. His procedure was to dilate the uterus well and cauterize with the galvano-cautery. He did not use the hot water douches as the water could not be used hot enough. The practice, too, called the attention of the patients too much to the uterus, which he considered a bad thing. Purgatives judiciously used were of great benefit. Whitely's exercises were valuable. He spoke also of the virtue of massage and electricity. Hamamelis and hydrastis were valuable in the acute and the sub-acute conditions. He thought hydrastis was more particularly suitable for hæmorrhages of the bowels, but not for the venous condition of the uterus.

Dr. Forfar spoke of the value of ichthyol.

Dr. Hay agreed that the operations of dilatation, curettement, and tamponage were of value ; but in the last operation care should be taken not to pack the internal os.

Dr. W. H. Oldright spoke of the various causes of this condition. He alluded to miscarriages as one of the most common. He thought it injurious to pack the uterus after this mishap. His plan was to curette and wash out with a solution of bichloridè of mercury 1-4000. He referred to the hygienic treatment. He disapproved in strong terms of abdominal constriction by corsets. Another point often neglected was the habit of going to the closet at regular hours. He did not wonder at the neglect of this duty in country places, where, as a rule, outhouses were cold, abominable places. Working women were often required to sit up too late at night and rise too early in the morning. To relieve the tendency to retroflexions which accompany this condition he recommended that the woman should lie on her back.

REFLEX AMBLYOPIA.

Dr. Wishart reported a case of reflex amblyopia without any lesion of the fundus observable by the ophthalmoscope. The patient gave the history of taking a journey in a driving storm of sleet which struck her in the right cheek ; neuralgia of the right side of the face supervened, which was accompanied by considerable pain about the right eye. But there was no inflammatory condition of the eye. After about a week the eyesight began to fail on the affected side, followed by total blindness. With the onset of dimness of vision pain entirely ceased. After a week's blindness the vision began to return slowly and in two months after she had a vision in that eye of 20-50. No fundus lesion could be seen. There were no refractive errors. The treatment was rest. Strychnine was administered. The pathology of the condition was very obscure. In DeSchweinitz's work several cases were reported where irritation of branches of the fifth nerve produced amblyopia. These disturbances usually came from the teeth. In the case reported the Dr. considered the cause to be reflex from the irritation of the cheek by the storm.

The society then adjourned.

 PATHOLOGICAL SOCIETY OF TORONTO.

THE first regular meeting for the season 1895-96 of the Pathological Society of Toronto was held October 26, 1895, at 8.30 p.m., in the east wing of the Biological Department Building, Queen's Park ; the president, Dr. Carveth, in the chair.

The programme was proceeded with as follows :

TISSUE FOR DIAGNOSIS.

Dr. Hamilton read a communication and presented a specimen for Dr. Mullin, of Hamilton. The specimen consisted of a piece of tissue which had been passed per rectum. It was referred to Dr. J. Caven for microscopic examination who suggested that it might be pancreas, although decomposition was very far advanced for microscopical section.

STAB WOUND OF INTESTINE.

Dr. John Caven presented a specimen showing stab wounds of the intestines. The first was situated in the upper part of the jejunum, close to the duodenum. The second was about one foot lower. The intestine had been slightly wounded in both places by one thrust of a pocket-knife, the wounds having subsequently enlarged by tearing. The victim was a muscular man of twenty-six years. He was stabbed while leaning forward

towards his assailant, who was seated, and whose right hand held the knife hanging by his side. He raised it with a sweep, so that the point entered in the left anterior axillary line, midway between the ilium and the ribs, the point directed forward and inward. At the post-mortem the abdominal wall was found infiltrated with blood, which lay chiefly between its muscular layers. Some clotted blood in abdominal cavity and a mild grade of peritonitis. Little or no fœces were present in the cavity of the peritoneum. The hæmorrhage into the peritoneum occurred principally from the wound in the abdominal wall.

DISLOCATION OF BOTH PATELLARS.

Dr. McKenzie presented a living specimen, a girl of thirteen, showing a double dislocation of the patellar, which occurred on flexion being reduced on extension, and occurring, therefore, alternately as she walked. On examination, the absence of the vastus internus was considered probable, although no satisfactory explanation of the absence had been arrived at. No definite history could be obtained.

Dr. Starr referred to a case occurring in the clinic of Mr. Bland Sutton, where a double dislocation of the patellar was found in a laboring-man, who walked and worked quite normally in spite of it.

In the discussion, Dr. Oldright suggested electricity as a test for the absence of the vastus internus, and Dr. John Caven thought that a peculiar distribution of the condition usually known as infantile paralysis might account for the condition found.

FRACTURE OF FEMUR.

Dr. John Caven presented a fracture of the neck of the femur occurring in a man of fifty years of age, due to the jar consequent upon slipping unexpectedly into a furnace pit. No symptoms of fracture were found at the time, but developed subsequently, a diagnosis of intracapsular fracture being made. A post-mortem was obtained nearly a year later. A history of pulmonary tuberculosis and chronic diarrhœa were obtained. The lungs and pleuræ were tubercular, and the large intestine was ulcerated throughout and much weakened and contracted. In the ilium a single tubercular ulcer, one inch from the ilio-cœcal valve, was found. The neck of the femur was absorbed and the head excavated, partial fibrous union and some tubercular granulation tissue being present. The convexity of the head and the cavity of the acetabulum presented erosion and granulation tissue.

In the discussion, Drs. Primrose and McKenzie mentioned that the late development of the symptoms of fracture in such cases was not rare. Dr. Graham considered that the tubercular condition weakened the tissues generally, the bones being affected with the others, but not specifically.

APPENDICITIS.

Dr. John Caven presented specimen of appendicitis from a woman. The cause of appendicitis had been looked upon as the bac. coli communis until recently, when Wilson, in addition to the ordinary cultures from the peritonitic fluid, from which this organism was obtained, made also cover-glass preparations which showed numerous other organisms, any of which may be responsible for the inflammation, but which fail to grow in ordinary media.

MENINGOCELE.

Dr. Primrose presented a specimen of meningocele from a child six or eight weeks old, which occupied the occipital region; ligation had been resorted to and recovery followed. Meningocele commonly occurs in this position and at the root of the nose. Hydrocephalocele, also, was common.

In the discussion Dr. Nevitt referred to the occurrence of such tumors at the lines of the sutures. Dr. Cameron thought that they were found more often out of than exactly in the middle line and referred to the frequent association of this condition with spina bifida. Dr. McKinnon, of Guelph, present as a visitor, mentioned a case of spina bifida treated by injection, and followed by a development of meningoceles at all the sutures of the skull.

CERVICAL GLANDS REMOVED.

Dr. Nevitt presented glands removed from the neck of a man of fifty years, apparently otherwise healthy. The large growth occurred rapidly and painlessly. It was easily removed, the glands shelling out readily.

Dr. Graham suggested a blood examination.

MITRAL LESION.

Dr. Aurgot presented a heart showing old mitral and bicuspid disease, with recent vegetations, for Dr. McPhedran, who was absent. Infarcts were found in spleen and lungs.

PELVIC PERITONITIS.

Dr. Clingan presented specimens for Dr. Thistle from a case of pelvic peritonitis following confinement in a patient suffering from gonorrhœa. Post-mortem showed adhesions of ovaries and tubes to bladder intestine. Muco-pus in uterus. Blood-stained serum in pelvis, with recent adhesions.

The meeting then adjourned.

The officers for the winter '95-'96 have been elected as follows: President, Dr. Carveth; vice-president, Dr. Primrose; treasurer, Dr. John Caven; corresponding secretary, Dr. Hamilton; recording secretary, Dr. Hibbert Hill.

THE WATERLOO AND WELLINGTON MEDICAL ASSOCIATION.

The regular meeting of the Waterloo and Wellington Medical Association was held at Berlin, on the 8th of November. Dr. Webb, of Waterloo, read a very thorough paper, his subject being "Practical Life Insurance Examinations." He laid special stress upon the necessity of systematic and conscientious examinations. During the discussion the question of fees was brought up, and the dollar fee for lodge work was rather roughly handled.

Dr. Brock, of Guelph, gave notice that he intends introducing a by-law at the next meeting, "That no member of this association shall examine an applicant for life insurance for a fee less than four dollars."

Dr. Necker's paper, "Report of Cases in Practice," was held over for the next meeting, in Guelph, Friday, 3rd January, 1896.

LONDON MEDICAL ASSOCIATION.

At a meeting of the London Medical Association held on Monday evening, December 9, the following officers were elected for the coming year: President, Dr. H. Meek; vice-president, Dr. J. Wishart; recording secretary, Dr. W. M. English; corresponding secretary, Dr. W. J. Weeks; treasurer, Dr. R. Ferguson. The present year has been one of the most successful in the history of the association, and the prospects are most encouraging for a pleasurable and profitable winter's work.

Book Reviews.

THE CARE OF THE BABY. A manual for mothers and nurses, containing practical directions for the management of infancy and childhood in health and in disease. By J. P. Crozier Griffith, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc. Philadelphia : W. B. Saunders.

This excellent book purports to furnish a reliable guide for mothers and nurses who have the care of children in sickness and in health. While agreeing that it accomplishes this, we desire to add that it will also be found useful for general practitioners. The directions referring to bathing, dressing, and feeding children of different ages are unusually clear and concise, although not neglecting certain details which are often overlooked. The doctor is sometimes apt to think that such details are somewhat out of his line of duty and, as a consequence, does not educate the mother in the right way as to the care of her children in health. In such cases, we think both doctor and mother should read and "inwardly digest" this book. The chapter on babies' diseases is a good one for physicians, but contains, we think, too much for mothers. Taken altogether, the book contains but little which deserves adverse criticism, and a great deal that is very commendable.

A MANUAL OF OBSTETRICS. By A. F. A. King, A.M., M.D. Sixth edition. Philadelphia : Lea Brothers & Co., 1895.

Though Dr. King says this work has no pretension to reach the elaborate completeness of a full-fledged treatise, we should consider the student who possessed the knowledge contained within this small book to be very well versed in the whole subject of obstetrics and admirably armed against the accidents of labour. The chapter relating to "The Signs of Pregnancy and Flooding" puts these subjects very clearly and systematically before the student and, like the rest of the work, are quite "abreast of the current ideas."

The Liverfel mode of arresting *post-partum* hæmorrhage is open to some objection, and in our opinion it is better to teach the modification of the method which does not permit the imprisonment of clots within the uterus, a condition which certainly does interfere with the proper contraction and expansion of that organ.

In an attempt to anglicize such words as *ante* and *post partum* hæmorrhage, (reading "ante-partal" and "post-partal") it seems to us that the difficulties of the student are doubled.

He cannot find "ante-partal" or "post-partal" in either English or Latin dictionary.

Are not such words as post-partum and post-mortem by common use anglicized already.

But these are very small differences on very minor points. The thanks of the general profession as well as the student are due Dr. King for having given to both what both much needed, a short and safe, a concise and complete guide to this most important branch of medical practice.

THE DISEASES OF CHILDREN'S TEETH, THEIR PREVENTION AND TREATMENT. A manual for medical practitioners and students. By R. Denison Pedley, M.R.C.S., L.D.S. Eng., F.R.C.S. Edin. With numerous illustrations. Published in London by J. P. Segg & Co 289 and 291 Regent St. W. ; in America by the S. S. White Dental Mfg. Co., Philadelphia, Pa., U.S.A.

Dentistry has made greater strides in America during the past half century than in Great Britain, but in endeavoring to educate the medical practitioner on the care of the teeth, the Britishers have made an important advance which it would be well for their American confrères to imitate. There are many diseases of the eye, ear, and other organs which the general practitioner scarcely ever treats, but, as a rule, leaves to the specialist. At the same time, a college training on these branches is necessary before the student is allowed to graduate in medicine ; and yet no attention whatever is given in the medical colleges of America to teaching even an elementary knowledge of the care and preservation of the human teeth. The teeth are, however, of as much importance to the ordinary human being, in his journey through life, as his eyes, ears, and other of his organs.

In his preface to the above work the author says :

"So numerous are the subjects to which the attention of the student of medicine is necessarily directed while passing through a hospital training that, in most instances, the dental department is neglected. It is when settling down in the country, where the area of practice is wide and the opportunities of obtaining skilled dental assistance are few, that the practitioner of medicine finds much reason to regret the absence of a knowledge of the diseases of the teeth and the means by which they may be prevented. As children form so large a proportion of the patients he is called upon to treat, I am not without hope that the general practitioner will find in the following pages some facts worthy of consideration. Although writing particularly for the student and practitioner of medicine, I have endeavored to embody in these pages information which I hope may prove of service to the student and practitioner of dentistry."

The work is, perhaps, somewhat too extensive for the wants of the general medical practitioner, and if the medical reader does not get a pretty fair knowledge of dentistry, it is not the fault of the author.

About fifty pages are devoted to irregularities of the teeth and about seventeen pages to the hygiene of the mouth, while the structure, corruption, and the decay of the teeth are treated in separate chapters. About sixty-five pages are devoted to treatment, and about twenty of the last pages of the book to the extraction, of the teeth. It would be well if physicians would always

study the extraction of the teeth last and the methods of preservation first, as there are entirely too many teeth extracted which might have been saved.

The above work fills a gap which should have been long before filled in the library of the physician.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES. A yearly report of the progress of the general sanitary sciences throughout the world. Edited by Charles E. Sajous, M.D., and seventy associate editors, assisted by over two hundred corresponding editors, collaborators, and correspondents. Illustrated with chromo-lithographs, engravings, and maps, in five volumes. The F. A. Davis Company, Publishers, Philadelphia, New York, Chicago. London: F. J. Rebman. Australian agency: Melbourne, Victoria.

Contents of Volume I.—Diseases of the Lungs and Pleura—Wilson and Eshner. Diseases of the Heart and Blood-vessels—Vickery. Diseases of The Mouth, Stomach, Liver, and Pancreas—Rubino. Cholera; Diseases of the Intestines and Peritoneum—Griffith and Hunt. Animal Parasites and their Effects—Dolley. Diseases of the Kidneys, Bladder, and Adrenals; Urinalysis—Lannois. Diabetes Mellitus—Lepine. Fevers—Semeleder. Diphtheria, Croup, Pertussis, and Parotitis—J. Lewis Smith and Warner. Scarlet Fever, Measles, Varicella, and Rotheln—Witherstine. Rheumatism and Gout—Davis. Diseases of the Blood and Spleen—Henry and Stengel. Volume Index—Devereux. Reference List of Journals.

THE first volume of this now well known work comes, like its predecessor, crammed with information concerning the various subjects with which it deals. A book of this kind is a welcome addition to a library, because it renders accessible the most valuable part of the work which has appeared in various ways during the entire year. In many instances valuable papers are reproduced in condensed form, *e.g.*, Dysentery, by Kruse and Pasquale, with chromolithograph of section showing amœbæ magnified 300 diameters; Appendicitis, etiology of, by H. Hodenpyl. The chapters devoted to lungs and pleura, and to fevers, are particularly exhaustive, containing reports in detail of results obtained by the multitude of treatments advised.

Contents of Volume II.—Diseases of the Brain—Gray, Pritchard, and Shultz. Diseases of the Spinal Chord—Obersteiner. Peripheral Nervous Diseases, Muscular Dystrophies, and General Neuroses—Sollier. Traumatic Neuroses—Booth. Mental Diseases—Rohe. Inebriety, Morphinism, and Kindred Disorders—Norman Kerr. Diseases of the Uterus, Tubes, Ovaries, and Pelvic Tissues—Montgomery. Diseases of the Vagina and External Genitals—Baldy and Dorland. Diseases of Pregnancy—Lutaud. Obstetrics and Puerperal Diseases—Budín and Merle. Diseases of the Newborn; Teratology—Currie. Dietetics of Infancy and Childhood; Infantile Disorders—Edwards. Volume Index—Devereux. Reference List of Journals.

VOL. II.—As in former years, the work done by the many editors is particularly good. The recent great advances made in the study of the diseases of the brain and spinal cord are reviewed and noted up to date. This, as in the other volume, renders the work of great advantage to the overworked practitioner who has not the time nor the literature at hand. The other sections are of equal value.

Contents of Volume III.—Surgery of the Brain, Spinal Cord, and Nerves—Pitcher and Lloyd. Thoracic Surgery—Gaston. Surgery of the Abdomen—Bull and Coley. Diseases of the Rectum and Anus—Kelsey. Surgical Diseases of the Genito-Urinary Apparatus in the Male—Keyes and Fuller. Syphilis—White and Furness. Orthopædic Surgery—Sayre. Amputations, Resections, and Plastic Surgery; Diseases of Bones and Joints—Conner and Freeman. Fractures and Dislocations—Stimson. Diseases and Injuries of Arteries and Veins—Fenger. Oral Surgery—Matas. Tumors and Surgical Mycoses—Laplace. Surgical Diseases—Tiffany and Warfield. Surgical Dressings and Antiseptics—Van Imschoot. Anæsthetics—Buxton. Volume Index—Devereux. Reference List of Journals.

VOL. III.—This volume is devoted mostly to surgical subjects. The sections devoted to the brain and abdomen are well and ably edited. The section on diseases of the rectum is chiefly devoted to the more common ailments and will enable the busy practitioner to keep posted on the common source of disease. The genito-urinary section contains many useful hints on practice. The section on surgical dressing is one that all general practitioners should peruse carefully. The successful man must keep advancing—must keep posted. These volumes are great aids in that line.

Contents of Volume IV.—Diseases of the Skin—Van Harlingen. Diseases of the Eye—Oliver. Diseases of the Ear—Turnbull and Bliss. Diseases of the Nasal and Accessory Cavities, Pharynx, Larynx, Trachea, and Œsophagus—Sajous. Intubation of the Larynx—O'Dwyer. Diseases of the Thyroid Gland—Clark. Legal Medicine and Toxicology—Draper. Medical Demography—Levison. Bacteriology—Ernst. Volume Index—Devereux. Reference List of Journals.

VOL. V., 1895.—We have from the F. A. Davis Co. Vol. V. of the Annual of the Universal Medical Sciences for 1895. It is unnecessary for us at this date to speak in recommendation of so useful and well established a periodical as this. Its value to all interested in the progress of medical science is beyond estimation.

Contents of Volume V.—General Therapeutics and Pharmaceutical Chemistry—Dujardin-Beaumez and Dubief. Experimental Therapeutics—Hare and Cerna. Electro-Therapeutics—Rockwell. Gynæcological Electro-Therapeutics—Apostoli and Grand. Hydrotherapy, Climatology, and Balneology—Baruch and Daniels. Hygiene and Epidemiology—Wyman and Banks. Anatomy—Testut and Vialleton. Normal Histology and Microscopical Technology—Sajous. Physiology—Howell and Dreyer. General Index—Kyle and Devereux. Reference List of Journals.

VOL. V., 1895, embraces therapeutics and pharmacy, chemistry, hygiene, climatology, anatomy and histology, physiology, microscopy, etc., and is on this account one of the best of the series. The summary of progress in microscopy and physiology, together with technology, is extremely good, and should be most useful to the practitioner who has not time to devote to the reading of special scientific records.

It can safely be said that Sajou's Annual of the Universal Medical Sciences *ought* to be in the hands of every active physician.

The following books and pamphlets have been received :

- PRINCIPLES OF SURGERY.** By N. Senn, M.D., Ph.D., LL.D., Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago ; Professor of Surgery in the Chicago Polyclinic ; Attending Surgeon to the Presbyterian Hospital ; Surgeon-in-chief to St. Joseph's Hospital ; Ex-President American Surgical Association, etc., etc. Second edition, thoroughly revised. Illustrated with 178 wood-engravings and five (5) colored plates. Royal octavo, pages xvi., 656. Extra cloth, \$4.75 net ; sheep or half-Russia, \$5.75 net. Philadelphia : The F. A. Davis Co., publishers, 1914 and 1916 Cherry street, and for sale by their Canadian agents, A. P. Watts & Co., 10 College street, Toronto.
- MATERIA MEDICA AND THERAPEUTICS.** A practical treatise with especial reference to the clinical application of drugs. By John V. Shoemaker, A.M., M.D., LL.D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia ; Physician to the Medico-Chirurgical Hospital, Philadelphia, etc., etc. Third edition, thoroughly revised. Reset with new type and printed from new electrotype plates. Royal octavo, pages ix., 1108. Extra cloth \$5.50 net ; sheep, \$6.50 net. Philadelphia : The F. A. Davis Co., publishers, 1914 and 1916 Cherry street, and for sale by their Canadian agents, A. P. Watts & Co., 10 College street, Toronto.
- A DICTIONARY OF MEDICAL SCIENCE. WITH THE PRONUNCIATION, ACCENTUATION AND DERIVATION OF THE TERMS.** Containing a full explanation of the various subjects and terms of Anatomy, Physiology, Medical Chemistry, Pharmacy, Pharmacology Therapeutics, Medicine, Hygiene, Dietetics, Pathology, Surgery, Ophthalmology, Otology, Laryngology, Dermatology, Gynæcology, Obstetrics, Pediatrics, Medical Jurisprudence and Dentistry, etc., etc. By Robley Dunglison, M.D., LL.D, late Professor of Institutes of Medicine in the Jefferson Medical College of Philadelphia. Edited by Richard J. Dunglison, A.M., M.D. Twenty-first edition, thoroughly revised, greatly enlarged and improved, with appendix. In one magnificent imperial octavo volume of 1,225 pages. Cloth, \$7.00 ; leather, \$8.00. Thumb-letter index for quick use, 75 cents extra.
- DUNGLISON'S DICTIONARY OF MEDICAL SCIENCE, TWENTY-FIRST EDITION, WITH APPENDIX.** Containing a full explanation of the various subjects and terms of Anatomy, Physiology, Medical Chemistry, Pharmacy, Pharmacology, Therapeutics, Medicine, Hygiene, Dietetics, Pathology, Surgery, Ophthalmology, Otology, Laryngology, Dermatology, Gynecology, Obstetrics, Pediatrics, Medical Jurisprudence, and Dentistry, etc., etc. By Robley Dunglison, M.D., LL.D., late Professor of Institutes of Medicine in the Jefferson Medical College of Philadelphia. Edited by Richard J. Dunglison, A.M., M.D. New (21st) edition, thoroughly revised, greatly enlarged and improved, with the pronunciation, accentuation, and derivation of the terms. In one magnificent imperial octavo volume of 1225 pages. Cloth, \$7.00 ; leather, \$8.00. Thumb-letter index for quick use, 75 cents extra. Lea Brothers & Co., publishers, Philadelphia, 1895.

Medical Items.

DR. R. A. DOWNEY (Tor., '95) will practice in Toronto.

DR. D. W. MCPHERSON (Tor., '95) has located at 201 Carlton street, Toronto.

DR. J. S. NIVEN, of London, Ont., has recently returned from a visit to his old home in Ireland.

DR. WILLIAM JOHN GREIG has been appointed an associate coroner in and for the city of Toronto.

WE notice by the *Canadian Medical Review* that Dr. W. A. Young is recovering from an illness of short standing.

SIR WILLIAM HINGSTON, M.D., is one of the candidates for Central Montreal in the coming election for the Dominion Parliament.

DR. GEORGE E. MILLICHAMP, youngest son of Ex-Ald. Millichamp, sailed Nov. 9, on the *Parisian*, for England; afterwards he will proceed to Germany.

DR. W. H. ELLIS, Professor of Chemistry in the School of Practical Science, Toronto, has recovered from his recent severe illness and resumed his regular work in his department.

DR. T. H. FARRELL, a recent graduate of Queen's University, Kingston, has been appointed junior assistant in the house staff of the Manhattan Eye and Ear Hospital, New York.

DR. L. M. SWEETNAM, who has recently undergone an operation at the hands of Dr. Howard A. Keely, has returned to the city and resumed his office work. The operation has resulted in a splendid recovery.

DR. FRED. G. GRASETT (Tor. '95), after passing the Tripple qualification examination in Edinburgh, went to London and will remain there a few months, after which he will return to his home in Jamaica.

DR. W. E. MACKLIN (Tor. '80), in a letter to Dr. Fred. Ames, dated October 27, states that he is in Nankin, China, working in a hospital he has established in that city, and "safe from the ravages of the Chinese mob."

DR. NORMAN MCL. HARRIS (Tor. '94) has recently returned to Toronto after having spent a year in England, where he obtained the licentiate qualification, L.R.C.P., London. According to his reports, the "boys" in London are working hard and doing well.

DR. H. C. BRUCE (Tor. '92) is still at work in London, and passed his primary examination for Fellowship of the Royal College of Surgeons of England in a very creditable manner. Dr. Don Armour (Tor. '94), Dr. W. D. Keith (Tor. '95), and Dr. Henry Paine (Tor. '95) are also in London.

THE Palisade Manufacturing Co. are offering six hundred dollars in prizes for essays on "The Clinical Value of Antiseptics, both Internal and External." Dr. Frank P. Foster, editor of the *New York Medical Journal*, has consented to act as judge, which is a guarantee of fairness in awarding the prizes. Further information can be had by addressing the company.

AT the last meeting of the Tri-State Medical Society (of Iowa, Illinois, and Missouri) the following officers were elected: President, Dr. Robt. H. Babcock, Chicago; first vice-president, Dr. A. H. Cordier, Kansas City; second vice-president, Dr. W. A. Todd, Chariton, Ia.; treasurer, Dr. C. S. Chase, Waterloo, Ia.; secretary, Dr. G. W. Cale, St Louis. The next meeting will be held in Chicago the first Tuesday, Wednesday and Thursday in April, 1896.

OBITUARY.

WILLIAM ARTHUR ALEXANDER MCPHERSON, M.D.—Dr. McPherson, a young physician of Prescott, died December 6, aged 26. The *Mail and Empire* says he had been suffering from kidney disease for some time, but nothing serious was anticipated, until he became suddenly ill Dec. 5, and died in twenty-four hours. He graduated from Queen's in 1890.

DR. FRANKLIN TOWNSEND, JR.—We learn from the *Buffalo Medical Journal* that Dr. Franklin Townsend, of Albany, New York, died October 31, 1895, aged 41 years. We in Toronto who had the pleasure of knowing Dr. Townsend and enjoying his generous hospitality will long remember him as a most charming and lovable man, and will receive the announcement of his death with very deep regret.

ALEXANDER WILLIAM JAMES DEGRASSI, M.D.—Dr. DeGrassi died at his home, Lindsay, Friday, December 6, after a long illness, from heart disease with certain complications. He received his medical education at Rolph's School, and the degree of M.D. from the University of Victoria College in 1867. He was well known for many years as a successful physician in Lindsay, and, apart from his professional reputation, was very popular with his large circle of acquaintances.

DR. LEWIS SPRINGER.—Dr. Lewis Springer, Registrar of the County of Wentworth, died suddenly at his home in Hamilton, aged 60. Although he took a regular course in medicine in New York State, he only practised a short time after graduating, as he was more interested in business undertakings. In 1882 he was elected member of the Legislative Assembly of Ontario, and in 1891 he was appointed Registrar of Wentworth.

SAMUEL ARTHUR BOSANKO, M.D.—Dr. Bosanko died at his home in Leadville, Colorado, on Saturday, November 23, from pneumonia. He received his medical education in the Toronto School of Medicine, and graduated in the University of Toronto in 1881. After graduating he went to Colorado, and settled in Leadville, where he soon acquired a large practice. We learn from Dr. Fred H. Ames that he was highly successful, and greatly respected by those who knew him.

DR. THOMAS KEITH.—Dr. Keith, the distinguished Scotch abdominal surgeon, died at his home in London, October 9, 1895, aged 68. He was best known through his work done in Edinburgh, in his private hospital. He moved to London in 1888, and resided there up to the time of his death. While in London he devoted much time and attention to the electrical treatment of fibroids; but failing health prevented him from doing much work during the last three years of his life.

DR. ROBERT BATTY.—One of the best known surgeons of the "Sunny South" was Dr. Robert Batty, of Rome, Georgia, who distinguished himself in both general and gynæcological surgery. It is generally understood on this continent that he devised the operation of removal of the ovaries—frequently termed Batty's operation. He himself thought the operation should be limited to a very small proportion of cases, but some of his disciples thought differently. Some of the latter have managed to keep out of penitentiaries—and that is about the best that can be said about them. Dr. Batty died at his home, November 8, aged 67.