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ROTO-LATERAL CURVATURE OF THE SPINE.*

BY R. E. M'KENZIE, B.A., M.D., TORONTO.

There are few affections in which the aid of the surgeon is sought that yield less satisfactory results in treatment than roto-lateral deviations of the vertebral column. To the family physician each case is a standing rebuke; drugs have but a narrow sphere of usefulness; time—that so frequently comes to our aid—renders the case worse; mechanical appliances prove themselves hurtful rather than helpful in the majority of cases; for treatment by exercise much individual attention is required, coupled with a careful study of each case and a considerable knowledge of gymnastics. Now, as when Edward Harrison† wrote, early in this century, "these cases have hitherto been intractable enough to deserve to be ranked among the *approbria medicorum*."

Little advance has been made in the pathology and treatment of this affection since Percival Pott‡ so graphically distinguished from other affections of the disease since recognized as Pott's disease. The clinical pictures drawn by John Shaw,§ James Wilson,|| and others, early

in this century, are equal to any that have been given in later times.

Curvature of the spine is much more common in girls than in boys, in the proportion of more than five to one. More than half of the cases develop before the tenth year, and congenital cases have been described. Usually the attention of the mother is first attracted by the condition of the shoulders or breasts. It is a common expression that "one of the shoulders is growing out," or that "one of the breast bones is out of its place." Occasionally attention is first called to the fact that "one hip is farther out than the other."

For purposes of clinical description, we here refer to two classes of cases, which differ in degree rather than in kind: First, those cases in which the deformity is slight and comparatively recent; secondly, those in which the deformity is more strongly marked, is of longer standing, is accompanied by deformity in the individual vertebræ, and by rotation.

When advice is sought in the first class of cases, it is usual for the mother to refer to a lack of symmetry of the shoulder blades, or to the fact that the ilio-costal space is deeper on one side than on the other. Any slight deviation of the spine from the perpendicular is likely to have escaped notice. Sometimes the distortion is first noticed by the dressmaker, who complains that it is impossible to make a rightly-fitting garment. The most noticeable curve, that in the dorsal region, is, in the vast majority of cases, towards the right. In such cases the

*Read before the Toronto Medical Society.

†Spinal Diseases, by Edward Harrison, 1827; preface.

‡Chirurgical Works of Percival Pott, Esq., vol. iii., pp. 427-493.

§John Shaw, "Nature and Treatment of the Distortions of the Spine," 1823.

||James Wilson, "Lectures on the Structure and Physiology of Parts Composing the Skeleton, and on Diseases of Bones and Joints," 1820.

right shoulder blade is displaced upward and outward, and is rotated about a transverse axis, so that its lower angle projects backward more than that of the left. Measured from the spinous processes between the scapulae, the lower angle of the right is farther away than that of the left. If the tips of the processes be followed downward and marked by a colored pencil, the parent's attention is, probably for the first time, called to the fact that there is a deviation from the perpendicular. In cases where there is but little deviation, no rotation of the vertebræ may be found; yet in comparatively slight cases careful examination will reveal a more pronounced roundness on that side of the spine next to the convexity. This is rendered more noticeable by having the patient curve the whole spine forward as much as possible, at the same time allowing the arms to hang loosely. Inspection in this attitude reveals even a very slight degree of rotation. The greater prominence on the side of the back next to the convexity of the curve is due to the vertebræ having rotated upon a vertical axis, so that the anterior portion of the body has made the greatest departure from the vertical. It follows from this that the actual curvature to the right or left in the bodies of the vertebræ is greater than is apparent by examination of the spinous processes, and that the transverse processes upon the side of the convexity are more posterior than those at the concavity of the curve. The first portion of each rib on the side of the convexity following the direction of the transverse processes is directed more backward than in the normal condition, while those on the side of the concavity, also following the direction indicated by the transverse processes, are less prominent than in the normal state. Following the ribs on the side of the convexity, their angles are found to be much more acute than the normal, and towards the anterior part the natural curve is lessened so that the front of the chest on that side is flattened. The ribs on the side of the concavity are correspondingly flattened behind and their curvature increased in front. The curve thus described is probably nearly always secondary to a curve in the opposite direction in the lumbar region, and is frequently accompanied by a third curve in the cervical vertebræ.

Many different causes have been assigned for

the deviations from the perpendicular.* The normal spine of the infant is a right line, and is capable naturally of bending in all directions. At a very early date a natural curve forward is found in the lumbar region, probably caused by a traction of the psoas muscles in the use of the lower extremities; this is naturally accompanied by a compensatory curve backwards in the dorsal region. The normal spine, when bent to the right or left, will permit a certain amount of flexion without rotation of the vertebræ around their vertical axes. Beyond this limit, however, rotation occurs as described above. Some causes which certainly are productive of this deformity may be enumerated.

Rickets, and all conditions of malnutrition of the child, render not only the bones, but all the tissues which go to constitute the spine and to hold it erect, less capable of maintaining the erect attitude, and constitute the chief predisposing causes. The force of gravity, operating through the necessity that the spine should bear the superincumbent weight of the thorax and its organs, the shoulders, arms, and head, tends to overcome the power of the spine to maintain its erect position. Any cause which even temporarily draws the spine away from its normal position enables this superincumbent weight to act with increased force in causing further deviation.

So long as a column of bones, such as the vertebræ, remain in a vertical plane, a great pressure from above may be resisted. This ideal condition, however, never exists; in the first place, the natural antero-posterior curves interfere with this ideal; and, secondly, in development few, if any, persons would be found entirely symmetrical if a vertical plane were passed from behind forwards through the centre of the body. Thus certain predisposing causes are supplied.

It is interesting to note some of the causes why this affection is so much more common in girls than in boys. Other reasons probably assist in bringing this result about; but I am of the opinion that the chief causes are, first, that the girls are not allowed such freedom in exercise and outdoor life as boys are, and, second, that the clothing employed by girls produces an unnatural constriction of the lower part of

* "The Spine in Infancy," Dwight & Rotch, *Archiv. Pediatr.*, March, 1891.

the thorax. Women in uncivilized nations have larger waist measurements proportionately than men, while the opposite is the case in civilized communities. In this way not only the muscles of the back are lessened in size and power, but the base of the thorax is so constricted that its mechanical power to aid in keeping the body erect is greatly lessened.

Chest diseases, such as empyema, which leave one lung in a permanently disabled condition, cause a very severe form of curvature, which is not amenable to treatment.

Seeing that the absolutely erect spine is but an ideal, not a reality, weakness renders slight causes operative in drawing the spine away from its position. The most frequent causes thus operating are found in the habits of children, such as throwing the weight entirely upon one leg when standing, sitting at the desk with one shoulder in advance of the other, etc. In fact, any attitude which is frequently assumed grows into a habit, and various tissue changes follow as a consequence upon the incorrect position maintained. Thus, if the weight of the body be thrown entirely upon the right leg, the left side of the pelvis is allowed to droop, the upper surface of the sacrum is in an oblique position, sloping downward to the left, and the axis of the lower vertebræ is directed towards the left side, thus causing a left lumbar curve, which must be compensated for by a curve toward the right, higher up, in order that equilibrium may be maintained. This position can be taken without causing any permanent change in the structures making up the spine, but if habitually assumed the intervertebral substances and the sides of the vertebræ upon the concave side become lessened by the greater pressure, and the parts on the sides of the convexity are permitted to increase in thickness. The muscles, also, and ligaments, intervertebral and others, upon the concave side, become shortened. The rotation which is normally produced in lateral bending is maintained, and thus permanent organic changes result. Another cause that is occasionally operative is found in the difference of length of the extremities, by which a tilting of the pelvis is produced, the base of the sacrum brought into an oblique position, and, consequently, the axis of the spine deflected from the perpendicular.

The slighter cases above referred to may generally be corrected by an effort of the patient, under the instruction of the surgeon. Where organic changes have not taken place, deviations considerable in extent may entirely disappear when a well-directed effort on the part of the patient is made to bring the pelvis to a level and the spine into the vertical plane. This is a most important circumstance to be noted in reference to treatment. It may be laid down as an axiom that the patient who can thus assume a correct position, even for a short time, may be educated into maintaining that position as a habit. Such cases form a class that are more amenable to treatment than any others. A second class consists of those who are able by an effort to lessen the degree of deformity; such patients may learn to hold permanently this amount of correction and to gain even further improvements. There is a third class who are unable by any effort of their own to produce any betterment in the distortion.

It is of course of the greatest importance that the general health of the patient should be looked after, and such constitutional treatment given as may be required.

Patients coming in the first class are better treated by the aid of systematic gymnastics, electricity, massage, etc. The second class, I believe, is best treated solely in the same way; but the third class can be helped only by various mechanical means of treatment.

No brief description can satisfy in giving an account of the systematic exercises* best adapted for the correction or improvement of these cases. It would be as unwise to treat all cases by the same exercises as it would be to treat all diseases by the same means. The habits in standing and in sitting, and in other attitudes, should be carefully studied, and everything tending to produce asymmetry should be avoided. The patient, unclothed down to the level of the trochanters, should be carefully instructed by the surgeon to assume an attitude that is the nearest approach possible to erectness; if necessary, one side of the pelvis should be raised by increasing the thickness of the sole of the shoe, so that the base of the sacrum may not tilt to either side. While the patient thus

*Heath's Dictionary of Surgery. "Roto-Latera Curvature of the Spine," Bernard Roth. *N.Y. Med. Rec.* Reginald Sayre, M.D.

maintains the best position possible, a variety of gymnastic exercises should be performed, cultivating such groups of muscles as the surgeon finds most called into use in bringing about this degree of correction. It is most important that this test position should be maintained. When weariness makes it difficult for the patient to maintain this corrected position, the exercises should cease and rest be permitted. The patient never feels at ease in this corrected attitude; the senses have become habituated to the position of deformity, and a restful feeling exists only when the deformed attitude is permitted. Consequently a re-education of the senses becomes a necessity, and the exact or corrected posture assumed by effort must become the *habit of life*. An important aid in bringing about this result is obtained by permitting the patient to exercise before a large mirror, maintaining at all times the best corrected position possible.

While electricity and massage may be general in their application, they should be given especially to the muscles and other tissues of the back and trunk.

In the use of all forms of portable mechanical appliances, the principle employed in the use of the plaster jacket is the best. By means of a suspensory attachment to the head, the spine is extended according to the judgment of the surgeon. This lessens to a greater or less degree the amount of deformity, and in this position the plaster jacket is applied, embracing the pelvis below and the thorax above. Thus the jacket becomes a double cone, and tends to maintain the body in its improved position. The disadvantages attendant upon the use of gypsum may be overcome by substituting for it the leather corset here shown, or the wooden corset made by Phelps, or other substitutes that have been employed for this purpose. Any portable appliance acting on a different principle, such as that with crutches in the axillæ, are worse than useless. A crutch under the movable shoulder can accomplish nothing in helping the patient to maintain a better position.

Against all such mechanical appliances it may be objected that they constrain the muscles of the trunk, producing atrophy and weakness, whereas increased strength is called for. This objection makes treatment by their use in the

first two classes unwarrantable; coming in the third class, however, are individuals who cannot work or be comfortable without some aid to support the body; in such cases these appliances are commendable.

Other mechanical means there are which may be employed with advantage where there is any permanent deformity. The inclined plane, having an attachment by which extension is made at the head while the body makes counter-extension, may be employed advantageously several hours a day and thus be made to alternate with the treatment above mentioned.

The difficulties that lie in the way of the surgeon in treating patients by gymnastics are so great as to be almost discouraging. One might as well prescribe for a patient so many pages of Hebrew or Greek and expect her to return regularly with the work accomplished as prescribe a series of gymnastic exercises and expect them to be followed out in the manner above described without a competent instructor to direct and accompany. I know of no plan by which this can be successfully carried out except by a regularly trained gymnast.

IS DIPHTHERIA OF LOCAL ORIGIN?

BY J. S. BENSON, M.R.C.S. ENG., CHATHAM, N.E.

During the prevalence of any epidemic so fatal in its effects as diphtheria, it is natural—nay, imperative—in the interests of his patients that every practitioner should carefully scrutinize every journal, consult every authority at his command, and exchange ideas with his professional confreres, in search of such remedies from which he may select and use those he may consider the most beneficial to each individual case. The tendency in most journals and standard works at the present day seems to be the acceptance that diphtheria is of local origin, and therefore the remedies must be chiefly local also, attacking the exudation vigorously with every conceivable kind of gargle, spray, and powder, with a view to destroy the local affection and thereby prevent systemic infection. Now, it may appear presumptuous in some to oppose the views of such men as Brettoneau, Oertel, Jacobi, Mackenzie, Bartholow, and numerous others equally famous. Still, it is the privilege of each one to accept or reject this or

that theory of disease as his ideas or common sense dictate.

I, for one, therefore, would like to ask a few questions, requesting explanation concerning certain facts in connection with diphtheria of those who claim that it is a disease of local origin.

How do they account for that period of incubation which precedes local manifestation? Incubation, as applied to disease, I understand to mean "that period which elapses between the introduction or entrance of a poison or morbid element into the system and the manifestation of certain symptoms produced by that poison whereby we may or can pronounce exactly what disease exists." During this period of incubation, then, which lasts from a few hours to a few days, varying in time in different cases, we find our patient complaining of headache, weariness, pains in back and limbs, high temperature and rapid pulse, loss of appetite, and furred tongue. Next we have intense hyperemia of the mucous membrane covering fauces, particularly the tonsils; and, lastly, we observe the exudation. Is this the order in which the symptoms should occur if the disease was produced by local infection first? What poison produced the symptoms accompanying that period of incubation? Was it not the very poison that produced the local appearance in the throat afterwards?

If local infection be accepted as the correct theory, then we must abandon the idea of any prodromal stage or incubation entirely or reverse the order in which the symptoms occur. Some authorities tell us some cases are constitutional, while others are of local origin. What are we to understand by this statement? Is it that, in cases where local manifestations are observed early, they think they have discovered the point of inoculation and designate such a case of local origin, whereas in those in which a period of incubation precedes the local affection and they cannot find or discover any point where the poison deposited itself, they say such cases must be constitutional? Take a case of small-pox. Are we to say that a case which has been produced by the entrance of the poisonous germ into the blood at some spot not visible is constitutional, and another that has been produced by intentional inoculation of local origin? Are not both constitutional?

And do we not accept or recognize in the appearance of the pustule produced by either inoculation in small-pox, or even vaccination, an evidence of systemic infection?

If the idea of local origin with subsequent contamination of the general circulation is correct, why, certainly, the entire and complete removal of the cause should prevent effects; hence, the proper and only sensible treatment, in accordance with such a theory, would be cutting or scraping off the exudation, penetrating well into the healthy structures. Supposing this were done, what is the result? Why, an immediate reforming of membrane. Now, from whence comes this new exudation? Certainly it is not produced by the old, because that has been entirely removed. It is undoubtedly produced by the same cause as the first one was, namely: The blood deposits it there, as the part selected in that disease, exactly in the same manner as small-pox, chicken-pox, measles, and scarlet fever select the cutaneous surface and produce the changes observed there.

Do the disciples of the local-origin theory advise the removal of what they say is the cause of the disease, the exudation? No; I think all with one accord say, No, do not disturb it. The practice and suggestions of many physicians are greatly at variance (I think) with the ideas they have put forth. For instance, Dr. Seibert, of New York, has invented an instrument (and a very ingenious one) for making sub-membranous injections, using chlorine water as the liquid. Now, what is the effect of this apparently simple operation? The fluid which is injected is at once carried away by the circulating blood and absorbents, and a puncture, representing the entrance of each of the half-dozen needles, remains. Is not each of these half-dozen punctures a separate opening for infection? I must note another peculiarity in his treatment, which is this: Dr. S. says a child may be disturbed frequently during the day and allowed to sleep six or seven hours at night. What guard does he leave in charge of the portals to the circulation during these hours of repose? Does he mean to say that the fluid he injects at night will remain in the tissues, actively working, during these six or seven hours? Or are we to believe that the diphtheritic bacilli

only migrate in daytime and rest calmly and serenely in the membrane during the night season?

Another plea for constitutional origin is this: Do we not find that, after elimination of the poison at any given point commences (as on tonsils), the symptoms of incubation subside, the temperature falls, the pulse becomes slower and remains so until convalescence is established, unless again disturbed by blood poisoning, which is ushered in by its own particular train of symptoms.

I must apologize for taking up so much space. My remarks may, however, call forth explanations for some phenomena which I cannot harmonize with the local infection ideas. My opinion is that diphtheria is a distinct, acute, infectious disease, produced by certain bacilli or germs which gain access into the blood by some invisible channel through the respiratory or alimentary tracts, which in their turn give rise to special symptoms, and select for their elimination and local manifestation the mucous membranes of fauces, especially the tonsils, and in some cases including the laryngeal and bronchial membranes—on all of which they deposit in form of an exudation in varying degrees of intensity and thickness, exactly in the same manner as the various exanthemata select the skin, occasionally involving the mucous surfaces as well.

I cannot see any ground for the idea of local infection, and feel confident that the man who attempts to check or cure diphtheria by local treatment will miserably fail. The only way to treat diphtheria is to do it in the same way as any other self-limited febrile disease. Maintain the general health by tonics (particularly the tincture ferri chlor.), nourishment, and the free use of stimulants. Try to steer clear of the quicksands of blood poisoning by endeavoring to preserve an aseptic condition of the exudation by antiseptic spraying. (I prefer the peroxide of hydrogen.) The only benefit that can possibly result from local treatment is the preservation of the exudation in an aseptic condition until the crisis is past, when it will, in due time, be cast off. Blood poisoning cannot take place without decomposition; therefore if we can prevent one we certainly prevent the other. All applications should be soothing, but strictly

antiseptic. The atmosphere of the room should be kept saturated with the vapor of eucalyptol, carbolic acid, and turpentine.

This treatment is virtually the same as applied to all self-limited diseases, namely, piloting, keeping a strict watch ahead, endeavoring to avoid shipwreck, which, unfortunately, is sometimes impossible, and our patient passes away in spite of all our efforts to save him.

NOTES ON TWO CASES OF COCAINE POISONING.*

BY A. J. HARRINGTON, M.D.

Case 1.—A female, *æt.* 44, who had what is commonly called an "attack of piles." I had previously seen the patient treated by Dr. Johnson by injecting 5 per cent. sol. ac. carbolic and glycerine into the piles, which gave her almost entire freedom from her ailment until about three weeks before the present attack, when she caught cold. At the time Dr. Johnson had operated he had used a five-grain suppository of cocaine, and it acted admirably, the patient saying she had not felt the hypodermic needle at all.

On this occasion I found her in great distress. She had to get up to the chamber every two or three minutes, when she passed a small quantity of bloody mucus, attended by great tenesmus. She had been taking morphia powders without relief. I prescribed a six-grain suppository of cocaine, directing her to hold it in the bowel until it was dissolved. This was at 2 p.m. I was sent for in haste at 3.30 p.m., and when I got there I found her in this peculiar condition: The fingers of both hands were extended rigidly and peculiarly white; the right side and right lower extremity were numb-like and had a feeling of formication, but were not spastic. The left side was unimpaired; pupils dilated. She was quite sensible. There was great dyspnoea, with dryness of throat. The friends had resorted to the time-honored custom of rubbing the hands with whiskey, so I directed them to continue this treatment and I gave her a hypodermic injection of morphia sulph. $\frac{1}{4}$ gr. and atropia sulph. $\frac{1}{100}$. In about half an hour she was perfectly her natural self. The urgent tenesmus, I may say, was effectually relieved, and, strange

*Read before the Toronto Medical Society.

to say, I saw her a short time ago and she says she has never felt so well in years.

Case 2.—A male, *æt.* 27, with painful micturition from urethritis. I advised him to use one of the $\frac{1}{4}$ grain tablets of cocaine mur. in his hypodermic case, dissolved in a little water, whenever he felt the strangury. He used the few tablets he had, and the relief was soon obtained on each occasion he injected it. Having no more tablets, he telephoned to me from his office, asking if a solution of cocaine would do as well. I advised him to inject a teaspoonful of four per cent. in the same way as before. I may here mention that he had a hypersensitive urethra, so much so, in fact, that 1 drachm of a solution of 4 grains to 1 ounce of soda bicarb. gave him great distress. As he was in the habit of using cocaine in his daily practice, I thought it unnecessary to give him more explicit directions. However, he injected ʒj. 4 per cent. solution into the urethra and bladder. Almost instantly the pain was gone. In about five minutes he felt a numbness in the gluteal and crural regions, with a sensation of fullness in the perineum and tingling of hands and feet. This soon spread throughout the whole system. The muscles of his legs gave way under him, and, being near the bed, he crawled upon it. There was now a buzzing feeling in the head, which was rather a delightful sensation, except that it was alarming. He tried to move, but had no muscular power. He could feel himself gradually becoming more powerless, and must have gone off in a profound sleep, which lasted until about 7.30 p.m., six hours after the injection. He was still very stupid, but managed to get to his telephone (he being alone in his office) and rang me up. When I arrived he was all right except for a feeling of tightness in the lumbar regions. I gave him a hypodermic of $\frac{1}{8}$ morphia, and next morning he was able to attend to his practice. The heaviness in his lumbar regions remained for several days. He had no more strangury.

In these two cases the action of the cocaine is peculiar. In case No. 1 the symptoms of overdose do not come on for $1\frac{1}{2}$ hours after its administration, although there was almost immediate relief to the urgent tenesmus and it was applied to the most absorbing of mucous membranes. Its effects soon passed off entirely.

In case No. 2 the symptoms appear in a few minutes and last several hours, and its remote effects last for several days. Was not it peculiar that the right lower extremity in case No. 1 was affected and not the left? Why were the small distal vessels of hands contracted? Why were the motor nerves affected and not the sensory? In case No. 2 the symptoms were unusually severe, although only half as much again of the drug was absorbed. Neither case could have been due to any fungoid action of the salt, as it was used dry in the first case and freshly prepared solution in the second. Were these cases of idiosyncrasy? I have used 5-grain suppositories very frequently. I have injected hypodermically 1 drachm 10 per cent. solution 6 grs. over bulboses with no bad effects at all, but with most gratifying results; yet these cases were exceedingly alarming ones, and have since made me less heroic in using this drug.

Selections.

A PLEA FOR EXPLORATIVE INCISION IN ASCITES IN WOMEN.

BY T. GAILLARD THOMAS, M.D.

An exceptionally large experience in the abdominal surgery of the female leads me to the conviction that many women go to their graves from ascites who might have been restored to health by surgical procedure.

The special causes of ascites may thus be enumerated as to frequency of occurrence:

- (1) Organic diseases of the liver.
- (2) Chronic peritonitis.
- (3) Tubercular peritonitis.
- (4) Malarial spanæmia, accompanying great splenic enlargement.
- (5) The existence of neoplasms within the peritoneal cavity.
- (6) The prolonged existence of excessive fecal impaction.

All these conditions, except the last, will so readily be admitted as common factors of the great symptom of which we are speaking that no special allusion to them will be necessary. The last will not be admitted by those who have had no personal experience of it. I will merely say that I have had such experience, and that I am

as perfectly convinced of the truth of my sixth proposition as to etiology as I am of that of the five which precede it.

Of these causes of ascites but three concern us here: The existence of neoplasms within the peritoneal cavity, chronic peritonitis, and that diseased condition of the peritoneum which has been styled "tubercular peritonitis." I allude to the last pathological condition thus doubtfully because it behaves in a manner so unlike tubercular disease developing in other parts of the body under the influence of surgical interference.

These three causes of ascites will, as to authenticity, be disputed by no one. All practitioners have in *post mortem* examinations met with instances of the second and third causes. As to the first, we see it in rare cases active with all varieties of solid tumor of the uterus and of fluid ones of the ovary. This is so well recognized as a fact that it requires no further consideration at my hands, so far as the general proposition is concerned. The special proposition which I would make in reference to them is this: that some cases of excessive ascites which by repeated tapplings prove fatal are due either to chronic or tubercular peritonitis, which is recovered from by opening the peritoneal cavity and draining it thoroughly, or to the existence of insignificant uterine or ovarian tumors which are too small for recognition, unless specially and carefully sought for, and the removal of which relieves the fluid accumulation, which by its exhausting influence destroys life.

I have met with a number of cases in which I have succeeded in completely curing aggravated cases of ascites after tapping had been repeatedly resorted to, and after all hope of recovery had been given up.

I shall not weary the reader by a report of all these, for the proof does not consist so much in a long array of cases as in the portrayal of a few select and characteristic instances which clearly point out the pathological conditions which have been assumed as factors, and give evidence of the restoration to health effected by their removal.

Case 1.—Mrs. C., of Durham, Conn., came to me suffering from ascites, for which she had been repeatedly tapped, and from which she was rapidly growing weaker, so that death at an

early period seemed certain. After each tapping a round hard tumor about as large as the head of a five-year-old child could be readily detected in the pelvis, and this could be obscurely felt even when the dropsical effusion existed.

I opened the abdomen as an explorative procedure, and, finding a fibroid attached to the fundus uteri, removed it. The patient is perfectly well to-day, the dropsy having immediately disappeared.

Case 2.—Mrs. B., of Canada, came to me with ascites, which was accompanied by the presence of a solid tumor over one ovary, as large as a cocoanut. She had been tapped once only. I removed a solid tumor of the left ovary and she entirely recovered, and has remained free from dropsy for two years.

Case 3.—Dr. Hurlburth, jr., of Stamford, Conn., sent me a patient suffering from ascites in whom I could detect, by vaginal touch, what seemed to be a pelvic neoplasm. I made an explorative incision, found a tumor in Douglas' pouch, no larger than an apple, which I removed, and the patient recovered from the operation and from the abdominal dropsy. The tumor, examined by Dr. Coe, pathologist of the Woman's Hospital, was pronounced sarcoma. One year afterwards I received the following report of the case from Dr. Hurlburth: "Since the operation the patient has been perfectly comfortable, but now a hard tumor can be felt occupying the pelvic cavity, and ascites is gradually beginning again to demonstrate its existence."

This patient lived in great comfort, Dr. Hurlburth has more recently told me, for six years, and then died of pneumonia.

Case 4.—This was a counterpart of Case 3, except that the post-uterine tumor was a benign fibroid attached by a rather slender pedicle to the posterior wall of the uterus. The patient, who was an inmate of the Woman's Hospital, left that institution at the end of a month well; but since that time I have lost sight of her.

It is very difficult indeed, I may say impossible, to tell why in a certain small number of cases these tumors create ascites, while in other cases they may occupy the peritoneal cavity for years without causing any such trouble; but that such is the fact is beyond question. As an illustration, I mention the following case:

Case 5.—I saw some years ago, with Dr. Emil

Noeggerath, a lady who suffered from severe enteralgia, which was created by the presence of an ovarian cyst as large as an adult's head, which was so migratory in its nature that it could be pushed anywhere in the abdomen from the pelvic roof to the diaphragm. As there was no urgency in the case, and as the patient and her friends dreaded surgical procedure to a morbid degree, we decided to avoid interference. Fourteen years passed, and I was again called in council by Dr. Noeggerath. The tumor was only about double the size which it had been fourteen years before, but its nomadic tendencies had created ascites, which was greatly distressing the patient, who now clamored for relief by surgery. I assisted Dr. Noeggerath in the removal of a monocyst with the longest pedicle that I ever saw in an ovarian tumor. The patient rapidly recovered, and has been ever since free from ascites.

It is rare to find even a monocystic ovarian tumor running so long a course; but I have removed one which had lasted for twenty-four years, another of sixteen, and another of nine years' duration.

In Dr. Noeggerath's case doubtless the extreme mobility of the cyst had a great deal to do with the resulting irritation of the peritoneum, and the development of dropsy. Such a complication of ovarian cysts is extremely rare.

I have treated quite a large number of cases of ascites due to chronic and tubercular peritonitis with perfect success by abdominal incision and drainage. To give the notes of more than one of these would be tedious and unprofitable, for they resemble each other very closely indeed. As a very good example of the class, I will give a short sketch of

Case 8.—Miss G., a young lady of nineteen years of age, was brought to me by Dr. Isaac Adler, twenty months ago, with a fluid accumulation in the abdomen, which had existed for five or six months, and had been accompanied by menstrual disorder, emaciation, a low grade of fever towards evening, and loss of appetite and strength. Regarding the case as one of ovarian cystoma, I made an explorative incision, in the presence of Dr. Adler and others, which revealed ascites, due to diffuse deposit of miliary tubercle scattered over the whole abdomen. A drainage tube was kept *in situ* for a month or

six weeks, and the patient made a rapid and complete recovery. Writing to Dr. Adler for news of her to render this history complete, he replies in the following words:

NEW YORK, NOV. 10th, 1891.

DEAR DR. THOMAS.

In reply to your lines inquiring after the health of Miss G., I am glad to be enabled to state that she is ostensibly in the best of health. Since the operation, which, as you recollect, took place in March, 1890, she has steadily gained in weight, weighing to-day about twenty-five pounds more than at the time of operation, and asserts that she is now in better health than ever before. Yours very sincerely,

I. ADLER.

The word "ostensibly" in Dr. Adler's letter rather weakens this case, but Dr. Adler in conversation assures me that the patient has had no return of the dropsy, is in perfect health, and anticipates marrying very soon.

Explorative incision, practised with antiseptic precautions now at our disposal, is not a dangerous procedure. If a good result attend it, a saving of life is the outcome; if it reveal an incurable or organic disease, no evil will usually accrue; and even if a fatal issue should be its consequence, we will be forestalling death by a short time only, in a praiseworthy effort at the securing of life.

It appears to me that with the evidence which is before us we should accept the following as a rule for practice: *In every case of ascites in woman, the propriety of explorative abdominal incision should always be carefully considered: not with the view of establishing a certain diagnosis alone, but with the reasonable hope of effecting in exceptional cases a cure.*—*Abstract N. Y. Jour. of Gynec. and Obstet.*

FORTY YEARS' EXPERIENCE IN THE USE OF CHLOROFORM.

BY LOMBE ATTHILL, M. D.,

Ex-Master of the Rotunda Hospital, Dublin.

The controversy as to the physiological action and safety of chloroform and ether respectively is being carried on as actively as ever; indeed, the report of the Second Hyderabad Commission—appointed mainly with the view of settling these points, and which affirms distinctly that death from the inhalation of chloroform is due to asphyxia, and which came to the conclusion

that chloroform, if carefully administered, was as safe as ether—has only served to intensify the controversy and stimulate those who hold contrary views to denounce its conclusions and to affirm more positively than ever that failure of the heart's action is the primary cause of death when such occurs.

I commenced to administer chloroform in the summer 1851, when I was appointed assistant to the then master of the Rotunda Hospital, and with the exception of about three months in the course of my own mastership of that institution, during which I tried ether, I have used no other anæsthetic—and in midwifery never any other

During the three months alluded to I employed ether in all gynecological cases. Amongst these were two of laparotomy, both of whom died, and I attributed their deaths to the effects of the ether. One of them was a fairly healthy woman, the subject of ordinary ovarian cystic disease. She objected greatly to the ether, declared she was being smothered, and began to cough immediately; this distressed her very much, was nearly continuous, and greatly interfered with me during the operation. On her recovering consciousness, the coughing became incessant. Bronchitis supervened, and ended fatally, a most unfortunate result to a promising case. In the other patient, who violently resisted the inhalation of the ether, vomiting set in before she was under its influence, recurred repeatedly during the operation, and on the withdrawal of the ether became incessant. Nothing was from the first retained on the stomach. She died on the fifth day. From that date I ceased to use ether, and I have never once given it since, except towards the end of a few very protracted cases, in which I substituted it for the chloroform, as being less depressing, but to this point I shall refer by and by.

I regret I am unable to give any precise details as to the number of cases in which chloroform has been administered in my practice. I can only say that during my term of office, first as assistant and then as master of the Rotunda Hospital, about fifteen thousand patients were delivered within its walls, and as chloroform was administered in every case of difficult or complex labor, as well as in many with the object of

relieving suffering, it was in constant use, and if to these be added the numerous instances in which I employed it in my private midwifery practice, I am satisfied that it was used by me in midwifery upwards of three thousand times. Indeed, I believe this estimate to be considerably under the mark, and amongst these there was never once cause of alarm, much less did a death occur.

I have again to regret my inability to make any accurate statement as to the number of cases in which I have administered chloroform in my gynecological practice, but certainly they have been over two thousand, that would be an average of only fifty cases for each year over which this retrospect extends; in truth I believe this estimate might be safely doubled.

The cases in which I have administered chloroform included every possible form of gynecological disease; amongst them were one hundred and twenty-five cases of abdominal section. Some of these were necessarily very tedious. I made it a practice never to hurry over an operation or to try to finish it within a stated time; in many cases I have kept patients under the influence of chloroform for considerably over two hours, but the longest time during which in any one patient complete anæsthesia was maintained by the use of chloroform alone was three hours and a half.

Now as to the result, I have had one death, but that I consider can hardly be laid to the door of chloroform; her life was lost through injudicious though well-intentioned treatment, adopted when respiration, perceived to fail, was being restored. The patient was the subject of an enormous ovarian tumor; it extended from the brim of the pelvis to the diaphragm, and was free from any adhesions. Chloroform was administered by Dr. Andrew Horne; the patient took it without making any objection, and had inhaled it only two or three times when Dr. Horne exclaimed that respiration had ceased. He at once withdrew the chloroform and commenced artificial respiration by extending the arms and drawing them upwards, and the patient immediately inspired deeply. At this moment one of the bystanders exclaimed, "lower her head," and some one seized her legs and elevated the pelvis, while another pulled her shoulders off the table till her head almost

touched the ground. The effect of this was that the huge tumor pressed downwards on the diaphragm, rendering inspiration impossible, and the patient never breathed again. I believe, and so does Dr. Horne, that but for this unfortunate act the woman would have been all right in a few minutes.

There is no doubt—and it is admitted on all hands—that chloroform is more energetic than ether, that it acts much more quickly, and that if given in a concentrated form it kills rapidly. In other words, it is a much more powerful agent than ether: is consequently more dangerous in unskilled hands; and that the patient requires to be more carefully watched by the administrator than if ether were employed. But, in my opinion, these are insufficient grounds for rejecting it, and I do not think they counterbalance the objections which exist to the use of ether, and which are very obvious: (a) The inhalation of ether is very irksome to the patient, and few patients who have subsequently taken chloroform are willing to take ether again. (b) It is most irritating to the air passages, and the irritation does not by any means always pass off when the inhalation is suspended. (c) Vomiting is more easily excited by ether than by chloroform; and when it does occur after the inhalation of chloroform, it is in general less distressing. (d) The effects of the ether, even when vomiting has not occurred or has ceased, last much longer: specially a feeling of nausea and the taste of the ether in the mouth remains a long time, and sometimes lasts for days. (e) Ether must be given in a concentrated form; if air be freely admitted anæsthesia cannot be produced: so the patient has to be half suffocated, and compelled to re-inhale air already expired; whereas, in using chloroform, pure air only moderately charged with the anæsthetic need be used.

In administering chloroform, three things are absolutely essential for its safe use: (1) The chloroform must be pure; (2) the apparatus used must be such as to admit air with the utmost freedom; (3) the administrator should give his whole attention to his duty, constantly and carefully watch the respirations of the patient, and frequently also feel the pulse, which is most easily done in the temporal artery.

As to the apparatus used, I give the decided preference to that known as Junker's. In it, the air being forced through the chloroform, it is impossible to administer it in a concentrated form; while, moreover, perfectly pure air enters the mouth pretty freely round the edges of the mouthpiece. For many years I have used no other. It is not so portable as Skinner's, which in midwifery practice answers well enough; but I never employ it in any surgical operation, and I believe that the immunity I have enjoyed from trouble is in no small degree due to my having long ago adopted this method of administering chloroform.

Some practitioners administer chloroform on a pocket handkerchief or piece of lint laid over the mouth and nose. I have never seen this done without having the account of the murder of Benhadad as given in the second book of Kings forcibly brought to my mind; and I would commend the study of that chapter of the Bible to all practitioners who think of using this dangerous method.

If chloroform is to be safely given, it is essential, in addition to procuring a pure drug and selecting the best inhaler, to see that the person who administers it, not alone understands what he has to do, but conscientiously carries it out.

Ether being a less powerful anæsthetic than chloroform, and being also less depressing, it can without doubt be given with somewhat less care than chloroform; and if neither a proper inhaler nor competent chloroformist can be obtained, it is better to use ether. Again, in very tedious operations, I generally deem it wiser to substitute ether for the chloroform after two hours have elapsed, not that I by any means do so always.

Perhaps I should add that whenever I have given ether I used Ormsby's inhaler, which, so far as I know, is the best.—*Brit. Med. Jour.*

DIVERTICULA FROM KNEE-JOINT.—The occurrence of diverticula from the knee-joint bulging into the popliteal space, or of enlarged bursæ in the same position, is, I feel sure, not unfrequently a symptom of rheumatic gout, or even of true gout. Amongst my cases for diagnosis (*Archives*, vol. i., p. 190), I have given a case of this kind in a lady whose father, as well

as herself, had suffered from gout. I have recently been attending a gentleman in whom first one knee and then the other was attacked. The knees became slightly swollen and very stiff, but there was very little appreciable synovial effusion, and he could still walk about. The principal objective symptom was bulging in the popliteal space. Under abstinence from wine and the use of alkalies, the conditions entirely disappeared. There was, however, a tendency to relapse on reverting to the same habits of diet six months later. From the behavior of the case, there could not be the slightest doubt that the knee symptoms were due to wine-drinking. They were therefore to be classed as gout rather than rheumatism. Two of the patient's uncles had suffered from chronic rheumatic disorganizing arthritis of the knee, and he himself had on one occasion had a transitory attack of free synovial effusion into one knee.

I remember well a case of this kind which was operated on by a colleague, many years ago, at the London Hospital. It was believed to be a bursa, but it proved to have a communication with the joint itself. The patient died of suppurative synovitis. This was before the days of antiseptic surgery. With modern precautions it does not, perhaps, matter very much whether the cyst be a diverticulum or an independent bursa, since the operation will be attended by scarcely appreciable risk. I doubt, however, whether even now it is advisable to operate in these cases. The popliteal swelling, whether purely bursal or otherwise, is usually only an accompaniment of arthritis, and is by no means the cause of all the stiffness and inconvenience. Its removal would probably, in the majority of cases, effect very little for the patient's comfort. In many cases patients go on for years with these swellings and find them but little impediment in walking. If operations for their removal are attempted, it is needless to say that they should be done with the strictest antiseptic precautions.

I have been induced to make the above remarks in consequence of having been consulted in the case of a gentleman who is the subject of swellings of this kind, and for whom an operation had been advised. He was about 40 years of age, and accustomed, in the pursuit of country pleasures, to take a great deal of exer-

cise. He, however, inherited gout, and had lived freely, drinking any kind of wine that came in his way. During the last few months a swelling had appeared in his left popliteal space, and it had increased to the size of a small orange. Pressure upon it made it bulge under the inner hamstrings. I could not satisfy myself that it was in any way possible to empty it into the joint. It was quite painless, and, excepting that it made the joint feel a little stiff, it did not incommode the patient in walking. During the week immediately preceding his visit to me, the commencement of a similar swelling in the opposite limb had been detected, and this had led to the proposed operation being deferred. I inquired carefully as to any symptoms of gout. Mr. C— assured me that he had never had that disease, but added, "I have been suffering lately from neuralgic pains in my joints." By this expression I found that he meant precisely the kind of pain which often occurs in association with tendency to gout. I advised that the operation should be deferred until trial had been made of drugs and a modified form of diet.—*Jonathan Hutchinson, in Archives of Surgery.*

A CASE OF UMBILICAL HEMORRHAGE.—On the 24th of December, 1890, I was called to see Mrs. E. She had been married eleven years; had had one child eight years ago. No miscarriages. She was a large, well-nourished woman and had always enjoyed excellent health. She was now eight months pregnant. On the preceding day she had taken a laxative. I was called to check a violent diarrhoea which had been in operation during the night and forenoon. She had considerable griping, but no uterine pains or uterine hemorrhage. No vaginal examination was made. Morphine was prescribed and in six hours I called again. She was then having labor pains, and the os was dilated to the size of a half-dollar. It was a face presentation. Labor progressed normally, and in four hours she gave birth to a male child weighing three pounds and a half. It was weak, poorly nourished, and had a pronounced "old-man" appearance. The possibility of hereditary syphilis was entirely eliminated by information from a thoroughly reliable source. The child was enveloped in cotton and en-

trusted to a competent nurse. It did well. On the fourth day the cord separated and the umbilicus assumed the usual appearance. By the eighth day it had gained considerable strength, and its battle for life seemed to have been won. On the afternoon of this day the nurse found the abdominal band stained with blood from the navel. When I called I ordered alum to be applied if there was any more bleeding. I was called in three or four hours, there having been a return of the hemorrhage which alum and other astringents had failed to control. I poured brandy over the navel, which immediately stopped the bleeding, and it did not return for six hours. Upon its reappearance, brandy was again tried, but without avail. Pledgets of absorbent cotton, saturated with Monsel's solution, were then pressed into the umbilicus and held there. This promised good results.

Dr. A. C. Wilson, of Youngstown, was called in consultation. It was decided to pack the navel with the saturated cotton and arrange a graduated compress over this, held in place by an elastic bandage encircling the abdomen. For eight hours no hemorrhage was visible, and the anxiety of the family and myself had somewhat abated. At the end of this time, to our dismay, blood was found oozing from beneath the bandage. A fresh dressing was applied, but to no purpose. I then placed my thumb upon the navel, and, with my fingers over the lumbar vertebra, the navel could be compressed against the bodies of the vertebrae, controlling the bleeding. The father and myself alternately compressed the umbilicus in this way for several hours, but eventually the blood would well up around the compressing finger with every movement of the now restless and almost transparent babe. Finally, no degree of compression we were able to make would control the hemorrhage. Our efforts were as fruitless as those of Sisyphus. At this juncture I obtained the consent of the family to transfix the umbilicus with needles. The needles were introduced at right angles to each other, going deeply into the tissues and crossing each other beneath the umbilical depression. The ends of the needles were approximated and a figure-of-eight ligature applied. This controlled the bleeding at once. After forty-eight hours the needles were removed,

and, happily, there was no return of the hemorrhage. The child rapidly gained flesh and strength, and now, at the age of eleven months, is a fine, healthy baby, never having been sick since this early experience.

Fortunately, these cases are rare, occurring only once in about five thousand births. The case reported in the *Journal* for October 31st by Dr. Wagoner is a very interesting one. The method of treatment which proved successful in his hands should not be lost sight of, as the high percentage (eighty-three per cent.) of deaths in these cases shows how inefficient treatment has been, and the success of this treatment, after the usual remedial measures had been tried and found wanting, bears testimony to its efficiency.—*R. H. Montgomery, M.D., in N. Y. Med. Jour.*

THE TREATMENT OF DIPHTHERIA.—To what extent principles of treatment of cases of infective disease may be modified by the acquisition of true knowledge concerning the nature of such affections is well shown in a paper read recently before the Clinical Society of Paris by M. Barbier, in which he dealt with the subject of diphtheria (*La France Médicale*, January 1st, 1892). He pointed out that the researches of Klebs, Loeffler, Roux, Yersin, and others, have now conclusively established that the pathogenic agent is a bacillus, which is only to be found in the false membranes, and does not penetrate either the blood or tissues. That discovery decides the much-disputed question of the "local" or "general" nature of the malady. The "false membrane is the disease," and the primary object of all medication must be to detach and remove it wherever it is accessible; for one removes thereby not only the morbid agent, but the toxalbumens which the microbe elaborates, and which are the source of the symptoms. But experiment also teaches that the bacillus does not develop on healthy or non-excoriated mucous membrane, and it is therefore of chief importance that the false membrane should not be detached violently, but gently and slowly. Cotton wool held in forceps gently and with frequent patient repetition brushed over the false membrane will gradually detach it, but care must be taken not to touch any other part. This is the first step. The next is to apply to

the affected area such an antiseptic solution as has been proved by experiment to destroy the bacillus. Under M. Grancher, M. Barbier had largely studied this subject experimentally, and found carbolic acid to be the best parasiticide for this purpose; and he now recommends the application of a mixture of sulphovinic acid (100) and carbolic acid (20) as more efficacious than carbolic acid and glycerine or olive oil, as hitherto adopted. This "*phenol sulfovinicé*" causes a transitory sensation of heat and burning, but its taste is not very pronounced, and, he says, children tolerate it well. Moreover, although frequently applied—every hour by day, every two hours by night—M. Barbier has never seen any sign of carbolic poisoning. Before applying it each time there should be practised free irrigation of the naso-pharynx, which aids in detaching more membrane, the warm water being rendered antiseptic by the addition of a small quantity of an alcoholic solution of salol (1 in 40). He claims for this procedure, vigorously carried out, a marked amelioration in the more serious signs of infection—the redness of the throat, glandular swelling, constitutional symptoms, and albuminuria. Similar principles he applies to the after-treatment of tracheotomy in laryngeal diphtheria; and he advises the prescription of calomel and naphthol to promote intestinal antiseptics, rendered necessary by the swallowing of portions of membrane detached from the fauces. Then general tonic treatment, with plenty of fresh air and sunlight, and avoidance of close rooms and steam. He gives no statistics, but he claims to have seen many good results from adhering thus rigidly to the teachings of the laboratory; and certainly there is no greater field for the study of diphtheria than the Paris Hôpital des Enfants Malades, where M. Barbier's observations have been made.—*Lancet*.

SUTURE OF THE ULNAR NERVE.—D.S.—, a young man, aged eighteen years, while playing with his brother in July, 1890, who had a large knife in his hand, accidentally turned round and cut him in the arm, dividing the ulnar nerve in the thickest part of the arm, about two inches below the elbow. Sensation along the course of the ulnar nerve in the arm was quite lost, together with all feeling on the inside of the ring finger and both sides of the little

finger. Considerable muscular atrophy of the arm and the ulnar side of the palm of the hand followed. The abductor minimi digiti and flexor brevis minimi digiti seemed quite lost, and the hand was quite flat on the outside. Galvanism, rubbing, and other means, I believe, were tried with no avail. On April 1st, 1891, nine months after the accident, the ulnar nerve was sutured. It was with considerable difficulty that the ends of the nerve could be found; they seemed to have become continuous with the surrounding tissues, and the cicatricial tissue seemed to make the ends still more tedious to find. At last I found the nerve, and then traced it up to its divided end. Having got one end out, the other end was found by at once cutting down on the course of the nerve from the ulnar, and tracing it to the divided end. If in future I have the same operation of suturing a divided nerve, I shall make the incision sufficiently long to be well on each side of the cicatrix, so that the nerve can be dissected out of its divided seat from above and below respectively. The nerve having at length been found, I vivified the ends, and with two fine silk thread sutures brought the cut or divided ends into nice apposition. The wound was then thoroughly cleaned out, all points of hemorrhage stopped, stitched up, and dressed with dry dressings. The wound healed up uninterruptedly with no drawbacks. On April 2nd (the day after the operation), at 9 a.m., which was three hours short of twenty-four hours from the time the nerve was sutured, the boy could feel distinctly when I touched him on the fingers or on the arm. On the 3rd (the second day after the operation), I asked the father of the boy to test his sensation. He did so with a feather by drawing it along the arm and on the fingers. Sensation was quite evident; the boy could feel distinctly whenever he was touched. I examined him again on Oct. 26th, 1891. The arm was considerably increased in size, but the palm of the hand on the ulnar side was still very much atrophied. The sensation along the course of the ulnar nerve still remained good. He could feel a pen lightly drawn along the course of the nerve, or over the parts supplied by it. The early return of the sensation after the suturing of the nerve seems very extraordinary; still, it is a fact, and it certainly did occur.—John F. Garner, M.D., in *The Lancet*.

TREATMENT OF CHLOROFORM ACCIDENTS.—In an article in a Russian surgical review, Prof. Bobroff recommends the employment of hypodermic injections of the physiological solution (0.6 per cent.) of common salt in case of failure of the heart's action during the administration of chloroform. He has employed this method for four years with satisfactory results, and considers it decidedly preferable to the subcutaneous injection of ether and other stimulants. With regard to ether, he says that it stimulates the cardiac action for a time only, afterwards having a paralyzing effect. Strychnine, atropine, ammonia, the previous administration of digitalis, and the inhalation of amyl nitrite, he considers more or less dangerous and by no means satisfactory, while the hypodermic use of the physiological solution of common salt is perfectly innocuous, and has proved in his hands very valuable. It is best not to wait for complete stoppage of the heart or respiration. If only a moderate quantity of blood has been lost before symptoms of danger show themselves, an ounce or so of the fluid is sufficient to inject; in anæmic patients, or where a large quantity of blood has been lost, $3\frac{1}{2}$ to 7 ounces may be required. The liquid is readily absorbed, especially if the locality is manipulated a little. The pulse becomes stronger, the respirations deeper, and the patient rapidly recovers. The solution may be made alkaline by the addition of 0.05 per cent. of caustic soda. Prof. Bobroff objects to the employment of such means of peripheral stimulation as affusion of cold water, the introduction of ice into the rectum, and putting ammonia to the nostrils, as these may by reflex action induce failure of the heart and arrest the respiration. The best and safest remedies are, he thinks, injection of solution of common salt hypodermically or into the venous circulation, lowering the patient's head, galvanizing the pneumogastric nerve, and the employment of Silvester's method of artificial respiration.—*Lancet*.

INFLUENZA A HUNDRED AND SIXTY YEARS AGO.—An Italian correspondent reminds us of the historic epidemic of influenza in Milan between the years 1730-33, described by the contemporary physicians, Drs. Gagliardi, Bellegatta, and Crivelli. The last named, a Milanese prac-

itioner in advance of his time, found in the air the "chief and efficient cause of the influenza visitation." In 1730 and 1733 the climatic conditions were as nearly as possible the same as those prevalent in the last two epidemics in Italy; that is to say, a mild temperature, the sirocco wind predominant, and much humidity, with fog and rainfall alternating. Dr. Crivelli's description of the symptoms of an influenza patient might (our correspondent says) be transcribed from the phenomena of to-day: "Gravedo and coryza, general languor with indisposition to exertion of any kind, loss of appetite even in presence of the daintiest viands, pain in the sinciput, giddiness, dimness of eyesight, high fever with rigors and *horripilatio* extending over the whole body; cough sometimes moist, sometimes dry enough to induce a choking sensation." These symptoms, not very grave in themselves, says Dr. Crivelli, are apt to reach an acute and even pernicious stage—"the patient finding himself suddenly oppressed with a suffocating catarrh (*un catarro soffocativo*), or, in other cases, with a pleurisy, or a pleuro-pneumonia. One patient falls as by an apoplectic stroke, another complains of intolerable cephalalgia—the old, the phthisical, the asthmatic, rarely outriding the storm." It would be difficult to give a truer account of the course and issue of the influenza cases now occurring at this hour in the Alta Italia. Dr. Crivelli further shows himself ahead of his age in his severe condemnation of indiscriminate venesection, stigmatizes the abuse of diluents, and rests his system of treatment on vigilantly regulated diet and the support of nature. Of course, he used heroic measures when time was precious—even bloodletting when engorgement of the circulation was a distressing symptom—and he found great efficacy in the Hippocratic prescription: "Alvus curanda est per clysterem subducentem et frigefacientem." Other less rational measures he also recommends, taken from a pharmacopœia happily superseded. But, according to the lights available at the time, he seems to have been a thoughtful and ingenious clinician, and his treatise has quite a special interest for the student of the history of medicine.—*Lancet*.

INFLUENZA AND LONGEVITY.—Whenever a period of low temperature or of fog, or of both

in combination, unfavorably affects our rate of mortality, the death-rate of the aged and of elderly persons shows a far higher rate of increase than the death-rate of the young or middle-aged, or even of infants. The veriest tyro of mortality statistics would recognize this as the natural result of the meteorological conditions above referred to. It may be noted, however, that as often as these conditions prevail, and the obituary notices in *The Times*, for instance, consequently show an unduly excessive proportion of deaths of elderly persons, some industrious paragraphist is sure to compile a statistical return showing the number of old people whose deaths have been advertised out of a given number of death notices announced during a given week. These figures are harmless enough in themselves, and useless enough, since no figures are ever given showing what are the normal proportions of the ages of the well-to-do classes whose deaths are so announced. The figures are, however, absolutely mischievous when the paragraphist or correspondent is allowed to draw inferences to the effect that this excessive and exceptional mortality among the aged affords evidence of increasing longevity. It is, however, a fact that during the past fortnight more correspondents than one in our lay contemporaries have referred to the fatal effect of influenza among the aged, judged by the obituary notices in *The Times*, as evidence of increased longevity. It is undoubtedly true that the proportion of deaths of elderly persons under the combined influence of low temperature, fog, and influenza has been abnormally high in recent weeks; but it is impossible to recognize any reasonable grounds on which this influenza mortality can afford evidence of increased longevity. Against such a misuse of statistics we feel bound to record our emphatic protest.—*Lancet*.

MEMORANDA ON THE FÆCES.—Differences in color, etc., of the fæces are often very misleading both to patients and practitioners. Very insufficient allowance is usually made for the direct influence of articles of diet. I have therefore put together the following memoranda in the hope that they may be useful to some of my readers. They contain, of course, nothing original :

The fæces are the remains of the food taken, modified by partial digestion and by the secretions which have been added.

Thus the color of the foods taken may often give the color of the fæces. Blackberries, whortleberries, and many other fruits, invariably give a dark tint. So also claret and red wines in general. Iron, as is well known, may make the motions black.

Carbonate of magnesia may make the fæces white.

A milk diet will give white or pale motions : so also, unless counteracted by other articles of food, may the use of white wines, champagne, etc., in the place of red ones. Self-observant patients are often deceived into thinking themselves out of health by forgetting some change of diet of this kind.

All sorts of green food, salads, spinach, cabbage, French beans, etc., tend to make the motions loose, and may make them definitely green. In children this may be so marked as to lead to the suspicion of bile disturbance.

Different purgatives may also modify the color of the stool.

Thus it may be broadly stated that the color of the stools, unless carefully estimated, is a very fallacious sign.—*J. Hutchinson, in Archives of Surgery*.

EXCISION OF ENCYSTED TUMORS OF THE SCALP.—In the case of the common encysted tumor of the scalp, the cyst itself should be freely opened from side to side. This is best done by thrusting a narrow, curved bistoury through the tumor and cutting upwards. The inexperienced are apt, as in the case of the meibomian cysts, to mistake the contents for the tumor itself, and thus leave the shell behind. I am accustomed to eject the cyst from its bed by pressing with the two thumbs, one on each side, the nail being made to dip well under the bottom of the cyst. In this way a dozen may be taken out in as many minutes. It is better not to cut the cyst into two halves, as it is easier to get it out if the posterior part remains whole. The thicker and more rigid the cyst, the easier it is to eject by pressure. When unusually thin, it may be necessary to drag it out by forceps.—*J. Hutchinson, in Archives of Surgery*.

POLYURIA IN PHTHISIS CONTROLLED BY FULL DOSES OF ERGOT.—By Wm. S. Barker, M.D., in *Medical News*. H.E., a mulatto, thirty-one years of age, entered the City Hospital, Nov. 7th, with well-marked symptoms of pulmonary tuberculosis. No tuberculous trouble could be located elsewhere than in the lungs. Whether the symptom about to be described was due to tuberculous deposit in the kidney or in the neighborhood of the controlling cerebral centres in the fourth ventricle could not be satisfactorily determined. During the preceding October the patient had for the first time been somewhat annoyed by frequent, copious, and persistent micturition. Examination of the urine gave the following result: Acid reaction; specific gravity 1004; no albumin, sugar, or casts. But the quantity of urine voided was very considerable, as following record will show:

	C.c.	Pints.
Nov. 14-15	5,000	10.0
" 15-16	10,400	20.8
" 16-17	8,200	16.4
" 17-18	10,600	21.2
" 18-19	9,100	18.2
" 19-20	7,200	14.4
" 20-21	6,000	12.0
" 21-22	4,400	8.8
" 22-23	2,400	4.8

The marked and steady decrease of urinary excretion after the 19th was due to the administration of rather large doses of fluid extract of ergot. One c.c. doses were given frequently, about 8-10 c.c. being taken daily. The quantity of urine at once began to diminish, and did so steadily each day, declining from 10,600 c.c. to 2400 c.c. per day, at which latter figure it remained until the dose of ergot was discontinued or was made much smaller, when a rapid rise in the quantity of urine took place. This was again brought well under control by increased doses of ergot. The patient succumbed to his pulmonary affection in a few months. Polyuria existed until shortly before death. The autopsy revealed only pulmonary tuberculosis.—*Medical News*.

THE VALUE OF THE IODOFORM-GAUZE TAMPON IN POST-PARTUM HEMORRHAGE.—Additional testimony as to the value of the tampon of iodoform gauze in treating post-partum hem-

orrhage is given by Staheli (*Correspondenzblatt für Schweizer Aerzte*, No. 21, 1891). In the clinic at Berne, nine fatal cases of post-partum hemorrhage occurred in 5424 births during a period of eight years. Of the nine, six were cases where anæmia was the immediate cause of death. In forty-nine cases in which the tampon was used, better results were obtained than by any other method of treatment. These cases were divided into two groups: one in which hemorrhage occurred from a source which was determined, and the other in which the tampon was used as a prophylactic against hemorrhage. In the first were cases of placenta prævia, transverse position, and other similar complications. In the second class were cases of contracted pelvis, and also of Cæsarean section. In using the tampon, strips of iodoform gauze are preferred; thorough antiseptic precautions should be taken to disinfect the patient and the material which is used.—*Amer. Jour. of Med. Sc.*

ON THE TORSION OF ARTERIES.—In connection with operations for excision of tumors, and other excisions of a like character, Jonathan Hutchinson remarks as follows: "I may mention that for many years I have quite ceased to use any other means for arrest of arterial bleeding than torsion. In excisions of the breast, for instance, I do not think that I have during the last fifteen years ever used a ligature. The torsion is always effected by a pair of Wells' clamp-forceps, now in such universal employment. I am always extremely careful to close all vessels, keeping the wound exposed for a considerable time for that purpose. Very seldom, indeed, have I encountered any secondary hemorrhage."—*Archives of Surgery*.

IMPORTANCE OF OPENING THE CAPSULE IN THE EXCISION OF CERTAIN TUMORS.—In the excision of ordinary fatty tumors, the knife should at the first stroke enter freely into the substance of the mass. They are enclosed in a cellular-tissue capsule, and this should be freely opened. If, instead of doing this, an attempt be made to dissect them out without wounding the capsule, the procedure will be long and tedious; whilst if the latter be only opened with sufficient freedom, they may usually be shelled out with

the finger. The same remark applies to adenocelas of the breast. It is scarcely possible in either case to cut into the tumor too freely.

—*J. Hutchinson, in Archives of Surgery.*

THE
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS
OF THE MEDICAL SCIENCES.

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.

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TORONTO, FEBRUARY 1, 1892.

THE MEDICAL COUNCIL AND THE
ANNUAL ASSESSMENT.

There can be no doubt about the fact that the action of the Medical Council with reference to the annual assessment at the last meeting is exceedingly unpopular with a large proportion of the profession in all parts of the province.

The following is the text of the enactment objected to :

"That the Registrar shall, on the 31st day of October in each and every year, send to each member of the College of Physicians and Surgeons of Ontario who has, up to that date, failed to pay his dues and to take out his annual certificate a registered letter addressed to the registered address of such member, informing him that unless the said dues are paid by the 31st December of that year his name shall be erased from the register of the College of Physicians and Surgeons of Ontario, and the Registrar shall erase the names from the register of all persons who have not paid their dues for one year, counting such year from the 31st December in one year to the same date in the next."

The opponents of this by-law have shown their disapproval in various ways, and many letters have appeared in the lay press. Some of the writers display strong indignation, while others show exceedingly bad temper. A discussion of such a question is always in order, but wholesale abuse of the members of the Council is, to say the least, quite unnecessary. It will scarcely serve any good purpose to try to prove that the

physicians of Ontario have elected a pack of designing scoundrels who have brought this province to the verge of ruin through dishonest investments in real estate and other nefarious transactions.

Upon the whole, we think few can doubt that the Council has done much for the profession of Ontario. Its members are, as a rule, desirous to do their duty by their constituents. Probably the majority are willing to acknowledge these facts, and have given the Council a fairly loyal support during the last few years, although by no means an enthusiastic one. The rather active delirium in some quarters over the two dollars' enactment has created some surprise; but there is abundant evidence that there is a deep feeling of resentment among many who are able and willing to denounce the action of the Council without becoming hysterical.

A good example of this was presented at the last meeting of the Huron Medical Association, when, after a discussion of the question, the following resolution, proposed by Dr. Graham, of Brussels, and seconded by Dr. Young, of Kirkton, was unanimously adopted :

"Resolved: That the members of this association desire to enter their most earnest protest against the objectionable section in the recently amended Ontario Medical Act whereby the power is conferred upon the Medical Council to erase a member's name from the register for non-payment of the annual fee, and that effort be made, by petition and otherwise, to call the attention of the Local Legislature to the fact: that the immediate repeal of section 27 of the Ontario Medical Act is greatly desired, and that a copy of this resolution be forwarded to the local members for Huron and Perth, and to the Hon. Oliver Mowat, to whom the medical men of Ontario now most earnestly appeal for support against this unjust legislation."

RESPONSIBILITY OF A HOSPITAL,
AND THE MEMBERS OF
THE STAFF.

An important decision was recently given by Judge O'Brien, of New York. It appears that in 1885 a Mr. Hartt, who had been a patient at the New York hospital, brought an action for damages for alleged ill-result of an operation. The question raised at the trial was whether the operation had been skilfully performed by the surgeon, Dr. Bull. A verdict was given in favor of the hospital.

A few months ago the plaintiff brought an action on the same grounds against Dr. Bull. The defendant's counsel put in the plea that, as the suit had already been brought against the hospital and had failed, the plaintiff had no standing in the court, his case having been finally disposed of. The judge concurred in this view and gave his decision in favor of Dr. Bull.

The *United States Medical Record*, in commenting on the case, speaks as follows:

"Let us see what might result in case a different view had been taken. Given a case in which, during the absence of the regularly appointed surgeon to a hospital, and the tenancy of a *locum tenens*, an operation is performed by one of the house-surgeon's assistants with unfavorable result.

"The patient brings suit against the hospital corporation, and, failing, sues the attending surgeon. Unsuccessful in this, he sues the *locum tenens* as representative of the surgeon. Then, in turn, the house-surgeon and the latter's assistant.

"The same case would go before successive juries, each time upon the same merits, but with a different defendant. The inconvenience and expense at which the hospital and its surgeons would be placed can well be imagined.

"It is a principle in law that in failure of an action against the master for the act of a servant, the same suit cannot be brought against the servant. Judge O'Brien, in his decision, looks upon the hospital as the master, and its medical officers as its servants. The man who pleads malpractice must elect whom he will proceed against, and must abide by the result of that trial."

POST-GRADUATE COURSE IN MEDICINE AT THE UNIVERSITY OF TORONTO.

As we before intimated, it is the intention of the Medical Faculty of the University of Toronto to give a post-graduate course of two weeks' duration, commencing in the latter part of May. The course will consist of both didactic and clinical lectures on subjects of general interest to practitioners, and the aim of the staff will be to make their work as practical as possible. A provisional programme has been prepared, and from it we get the following particulars: Drs. L. McFarlane, G. A. Peters, and B. E. McKenzie will take General and Special Surgery; Drs. Graham, McPhedran, W. P. Caven, and Jno. Ferguson, Practice of Medicine; Dr. A. H. Wright, Obstetrics; Dr. J.F.W.

Ross, Abdominal Surgery; Dr. Oldright, Sanitary Science; Dr. Jas. M. MacCallum, Therapeutics; Dr. Avison, Materia Medica; Dr. Jas. Thorburn, Life Insurance; Dr. A. Primrose, Surgical Anatomy; Drs. Reeve, Burnham, McDonagh, and J. D. Thorburn, Diseases of Eye, Ear, and Throat; Professor Ramsay Wright, Bacteriology; Dr. John Caven, Pathology; Dr. A. A. Macdonald, Diseases of Children.

Meeting of Medical Societies.

CLINICAL SOCIETY OF MARYLAND.

WM. T. WATSON, M.D., *Secretary*.

Baltimore, December 18th, 1891. The 259th regular meeting was called to order by the president, Dr. Robert Johnson.

Dr. Wm. B. Canfield read a paper on

DUST AS A CAUSATIVE FACTOR IN PULMONARY DISEASE.

The various kinds of dust may be divided into animal, mineral, and vegetable. Opinions differ as to which kinds are most dangerous when inhaled. That which is generated in brush factories is animal and very harmful. Makers of hats, especially felt hats, suffer much from the dust evolved. The vegetable dust that does the greatest and most lasting injury to the lungs is that generated in tobacco factories. This dust has not only a mechanical action, but has also poisonous effects.

It is in connection with the inhalation of mineral dust that the greatest amount of scientific investigation has been made, especially in relation to the diseases called the consumption of grinders, miners, potters, etc. Anthracosis, silicosis, siderosis, chalcosis, tabacosis, and other kindred names, have been suggested to describe a similar condition produced by various kinds of dust. Zenker has handed down the word "pneumo-noxoniosis" to cover all these conditions. The history of these cases is very much alike. They begin with simple bronchitis, which gradually becomes chronic. They are usually non-tuberculous, at least at the beginning; tuberculous complication is only an accident.

When one is exposed to an atmosphere of dust, the contact of this dust with the sensitive nasal and laryngeal mucous membrane sets up coughing and sneezing and much of the dust is expelled, and for a time no harm results; but a continual exposure to this dust causes a congestion of the mucous membrane of the nose and breathing passages, and in time an inflammation of the whole tract, the ciliated epithelium loses its power, and dust finds its way to the ultimate ends of the lung tubules. When the individual is asleep or absent from this irritation, the ciliated epithelium gets rid of a large part of this foreign substance, and the wandering cells may close around some of this dust and try to carry it off or render it harmless by burying it in a lymphatic gland. Much, however, finds its way either through the epithelium or between the cells into the submucous layer, getting into contact with

the connective tissue of the alveoli and by irritation causing a hypertrophy of this tissue and a condition resembling chronic interstitial pneumonia or fibroid phthisis. The general opinion seems to be that the fibroid condition seems to oppose a direct barrier to the growth and multiplication of the bacillus tuberculosis, and in large tracts of lung tissue converted into this material often not a bacillus could be detected. In one case of the author bacilli were found in abundance, and yet two years afterward the man reported himself as entirely well.

The color of expectoration is a prominent sign in these cases. In one of the author's cases, a stoker, the expectoration still continues absolutely black at times and always tinged, although it is almost two years since he gave up his occupation. Examination of this sputum under the microscope showed it to contain in abundance carrier cells, which in all cases contained pigments, and in some instances the black crystalline coal could be recognized within these cells. This pigment and foreign material has a tendency to collect at the apices of the lungs, and is only present at the bases when the dust inhaled is excessive in amount and exposure prolonged.

In diagnosis physical signs do not yield as much as the microscope. By the microscope we see the cells containing the dust. In the author's cases (4), râles were heard on auscultation, but nothing marked was obtained on percussion.

The prognosis is good if the man has not worked too long at the occupation. The treatment is to take the patient from his dangerous occupation, when improvement begins at once. Owners of large factories are adopting stringent prophylactic measures in order that they may not lose so many good workmen. The best methods are: (1) To prevent the formation or escape of dust by using wet grinding or by grinding in closed vessels. This is not always practicable. (2) To prevent inhalation of dust by using respirators, etc. But these are uncomfortable and the men remove them at every opportunity. (3) The removal of dust as fast as it is produced by using fans and air shafts. This is by far the best plan. Still further, the following rules should be enforced: (1) Workmen should change their outer clothing after work. (2) They should keep their faces and hands as clean as their work will allow. (3) They should never be allowed to eat in the work-room.

Dr. Randolph Winslow related a case of

ELEPHANTIASIS SCROTI.

J.C., colored, æt. 44, was admitted to the University Hospital, September 7th, 1891, on account of enlargement of the scrotum and perineum. His father died of meningitis and his mother of phthisis. Patient is one of seven children, six of whom died of phthisis. He had measles in childhood, typhoid fever at 21, and gonorrhœa about eight years ago. The present disease began about three years ago, with slight thickening of the tissues of the scrotum, penis, and perineum, the infiltration first showing itself in the skin of the scrotum and increasing slowly until at the time of his admission the scrotum was enormously enlarged and reached one-third of the distance to the knee. There were a number of suppurating sinuses and superficial abscesses in the scrotum and perineum.

There was some pain. The tissues of the scrotum were brawny and very little impression could be made on them by pressure. The perineum was composed of similar tissue and was enormously hypertrophied. The skin of the penis was also thickened, but retained its suppleness, and the prepuce could be easily retracted. The patient said that his virile powers were unimpaired. He was a sailor, but had never been much beyond the coast of this country, and had never resided in a tropical country.

Several efforts to detect the *filaria sanguinis hominis* were unsuccessful. The sinuses were incised and a long incision made in the perineum to relieve tension and allow the lymph and blood vessels to empty themselves. He was placed upon iodide of potassium, as syphilis could not be excluded. He did not improve, and excision of the scrotum and perineal hypertrophy was performed Oct. 1st. The skin and subcutaneous tissues were very dense and thick and freely supplied with blood vessels. The testicles were carefully dissected out and were uninjured. The gap in the perineum was closed with sutures, but there was not sufficient tissue to cover the testicles, hence lateral incisions were made in the contiguous skin and strips of skin dissected up and brought over so as to form a new scrotum. The tension was great and the stitches cut out, allowing the flaps to separate considerably. Healing was effected under about five dressings, and he was discharged well on Nov. 8th, relieved of pain and discomfort, and ready again to resume his ordinary avocations.

Clinical Notes.

CARCINOMA OF THE CARDIAC END OF THE STOMACH.

BY E. E. KING, M.D.

'I have pleasure in reporting a case that occurred in my service at the House of Providence which, if my judgment is correct, is one of extreme rarity. The history is exceedingly brief, which will also add interest to the case. Mrs. McC., æt. 77, been in the institution since Jan., 1891. She was not admitted on account of any illness, but to give her a comfortable home. Her symptoms have been few and of no special moment; simply complaining of headaches and a pain in the left heel. Appetite has been fair; rarely she vomited, never with blood. Two weeks prior to her death, she had a severe hemorrhage from the bowels of dark coffee ground color; it ceased without treatment within twenty-four hours; two slight hemorrhages during the next ten days. Three days prior to her death another hemorrhage, similar in character, occurred, and to this was my attention first drawn; I looked on it as coming from the bowel, and adopted treatment

for such, but without result. She died on the third day.

Post mortem: The stomach was found to be the seat of carcinoma, in its lesser curvature, at the cardiac end. It was about as large as a Mexican silver dollar, forming a well-marked cup-shaped ulcer, with sharp, clear-cut edges. There appeared to be a strip of healthy mucous membrane between the edge of the ulcer and the œsophagus. There was no narrowing of the œsophagus; large numbers of secondary deposits were found in the liver. No other organ was found involved.

Remarks: The occurrence of carcinoma of the cardiac end of the stomach is denied by Fagge, and suggests that all these cases arise in the œsophagus and spread to the stomach. The *post mortem* appearance in this case would strongly hold one to the opinion that this is a true case of cancer of the cardiac extremity. Welsh says that out of 1,300 cases of cancer of the stomach analysed, eight per cent. were of the cardiac extremity. The absence of symptoms is one that must strike all, since the disease must have existed for a long period, but the situation favors freedom from pain, the irritation being almost *nil* at this point. The hemorrhage and its character are peculiar, and fatal hemorrhage only occurs in twelve per cent. of these cases. The advanced age of the patient, the freedom from symptoms, and the discovery of the disease on the *post mortem* table, all go to make this case of peculiar interest.

Book Reviews.

A History of Medical Education from the most remote to the most recent times. By Dr. Theodor Puschmann, Public Professor-in-Ordinary at the University of Vienna. Translated and edited by Evan H. Hare, M.A. Oxford, F.R.C.S. England, L.S.A. London. London: H. K. Lewis, 136 Gower Street. Toronto: J. A. Carveth & Co.

The author of this very interesting book has endeavored to give a systematic exposition of the history of medical education in all ages and in all countries. He refers to the methods of healing in the earliest times, and the formation of medical craft founded on empirical methods. In reference to India, the first country he deals

with, he says: "The roots of our civilization lie in the east. On the banks of the Ganges, on the plains of Egypt, and in sea-girt Greece, thousands of years ago, arts and sciences flourished and attained a remarkable development. The healing art there also celebrated its earliest triumphs. It was in India at first practised by the priests, who there, as elsewhere, passed as the treasurers of all knowledge, human and divine." Gradually a distinct medical class was developed, and systematic rules and methods in teaching were recognized. The author refers to old medical works in Sanscrit literature, including commentaries by Charaka and Susruta. Charaka, in those ancient times, gives advice that might well be considered by modern surgeons, such as the following: "Never should even the wisest become puffed up with his wisdom. Many recoil even from a man of skill if he loves to boast. And medicine is by no means easy to learn; therefore let each one practise himself in it carefully and incessantly." The evolution of the practice of medicine in other countries is described in the following order: Egypt, Palestine, Persia, Greece, Rome. The rest of the work comes under the following heads: "Medical teaching in the middle ages, in recent times, and in modern times." On the last page we find the following quotation: "The most precious capital of states and of society is man. Every individual life represents a definite value. To preserve, to maintain it intact, as far as possible, up to the unalterable limits of its duration, is not only a precept which humanity teaches; it is the duty of every commonwealth in its own peculiar interest." With reference to this the author says: "In these words the Crown Prince Rudolph of Austria, unhappy in his early death, struck the keynote of a policy which sounds like the evangel of times to come." The book as a whole, from beginning to end, is replete with matter which is both useful and interesting, and, at the same time, presented in a graceful and charming style.

History of Circumcision: Moral and Physical Reasons for its Performance. By P. C. Remondino, M.D. Philadelphia and London: F. A. Davis, 1891.

Although one may be startled at reading that the prepuce has outlived its usefulness, and that

to be uncircumcised is to be uncivilized, yet, after the perusal of this work, one must certainly confess that the author has made a very strong argument for the more frequent performance of circumcision as a matter of personal hygiene, and as preventive of many forms of disease. Interesting throughout, the book may be recommended as a most exhaustive exposition of the subject of circumcision.

Essentials of Physiology. By H. A. Hare, B. Sc., M.D., Prof. of Therapeutics and Materia Medica in Jefferson Medical College, Philadelphia.

The third edition of this work has been much improved by the addition of some excellent plates from Arnold's "Icones Nervorum Capitis." The general text is of little more value than that of other books of the kind. If a student is unable to discover the "important points" or to "formulate ideas" when reading a standard work on physiology, he will be much less able to remember the ideas when formulated for him by another.

A Complete System of Gynecology and Obstetrics, with 869 new illustrations based upon translations from the French of Pozzi, Auvard, and others, revised by Chas. Jewett, M.D., bound in leather or half morocco, \$8.00. *Flint's Condensed Complete Encyclopedia of Medicine and Surgery*, arranged upon a new system, and embodying the various methods of treatment employed by eminent practitioners; the result of a year's labor of a large corps of writers. Leather or half morocco, two volumes, \$8.00 per volume. The above works sold by subscription. Also in press, ready March 1st, *The Electro-Therapeutics of Gynecology*, by Augustin H. Goelet, M.D. Cloth bound, \$2.50. New York: J. B. Flint & Co., publishers.

Wood's Medical and Surgical Monographs for Nov., 1891, contain The Practice of Hypnotic Suggestion; an elementary hand-book for the use of the medical profession, by Geo. C. Kingsbury, M.A., M.D.; and a Practical Manual of the Bacteriological Analysis of Water, by Dr. Miquel.

Personal.

At the annual meeting of the Huron Medical Association, held in Seaforth, Jan. 5th, the following officers were elected: President, Dr. H. R. Elliott, of Brucefield; vice-president, Dr. P. Macdonald, M.P., of Wingham; secretary, Dr. W. Gunn, of Clinton.

DR. GEORGE ORTON, of Winnipeg, ex-M.P. for Centre Wellington, has taken the practice of his late brother, Dr. Richard Orton, of Guelph.

DR. HAGERTY, who left London, Ontario, in 1877, for Portage La Prairie, Manitoba, where he resided for many years, died recently in California.

Therapeutic Notes.

ZANE (F.M.) ON PHENACETINE IN WHOOPING COUGH.—Phenacetine, in the author's experience in the treatment of whooping cough, gives more satisfactory results than any other remedy. It robs the disease of half its terrors, the spasmodic cough is less frequent and severe, febrile phenomena and serious complications are rarely present, and the disease runs a much milder and shorter course. To an infant four days old he gave half a grain every two hours to control a severe spasmodic cough, but the cough continued to increase in severity until the child had clonic convulsions, when he gave one grain every two hours. The spasms ceased, the cough improved, and the child recovered. The medicine was continued in this case for two weeks, at intervals of two, four, and six hours, according to severity of cough. He usually prescribes from half a grain to two grains every two, four, or six hours, according to age and urgency of the symptoms. It is best given dry on the tongue, followed by a little milk, or, in case of an infant, let it nurse immediately after placing the powder in its mouth.—*Kansas City Med. Record*, October, 1891.—*Epitome*.

SUBCUTANEOUS INJECTIONS OF STRYCHNINE IN TEN CASES OF CHRONIC ALCOHOLISM.—Dr. Ergloski has published an account of ten

cases of chronic alcoholism among his patients. They had the habit of taking brandy. They were given subcutaneous injections of nitrate of strychnine, and one-sixtieth to one-twentieth of a grain at each injection. After a dozen injections the results were remarkable, as they all acquired a distaste for brandy. In such cases as are desirous of being cured, this treatment may prove to be of assistance.—*Boston Med. and Surg. Jour.—Med. Age.*

CODEIN AND HYOSCINE IN PARALYSIS AGITANS.—Dr. Frederick Peterson publishes a clinical study of forty-seven cases of this disease. In the majority of his cases it developed between the ages of fifty and sixty, more men being affected than women. Codein in doses of two grains, combined with hydrobromate of hyoscine, doses of 1-100 of a grain, is recommended to be given two or three times a day.—*Med. Age.*

BROMIDROSIS.—In bromidrosis of the feet, a writer in the *Therapeutische Monatshefte* recommends the following :

R.—Acid. salicylic.
Aluminis.
Pulv. oryzæ . . . aa ʒss.
M.

Sig.—To be sprinkled in the shoes and stockings every morning.

This will act better if the feet are first washed with a three per cent. solution of chromic acid.

PAPOID IN DIPHTHERIA.—We find the following in *The Prescription* :

R.—Papoid gr. x.
Aquæ ʒ ss.
M. f. solution.

Kohts and Asch painted diphtheritic membranes with this solution every fifteen or twenty minutes with a soft brush. They found that the oftener the application was made the more rapidly membranes disappeared. Kohts treated several hundred cases by this method with the greatest success.

R.—Papoid ʒ ij.
Beta naphthol gr. iij.
Acid hydrochl. dil. gtt. xv.
Aq. destil. ad ʒ iv.
M. ft. solution.

Sig.—Use carefully and thoroughly by means of hand atomizer every half hour on throat and through nostrils on posterior nares and pharynx, if deposit extends to these localities. Papoid solutions should be made fresh daily.—*St. Louis Med. Jour.*

Miscellaneous.

THE PAN-AMERICAN MEDICAL CONGRESS IN THE UNITED STATES OF COLOMBIA.—Pursuant to nominations by Dr. Pedro M. Ibáñez, of Bogota, member of the International Executive Committee for the United States of Colombia, the following organization of the Pan-American Medical Congress has been effected in that country: Vice-President, Dr. Pio Rengifo, New York; Secretaries of Sections—General Medicine, Dr. Ignacio Guterrez Ponce, Paris; General Surgery, Dr. Rafael Rocha Castilla, Bogota; Military Medicine and Surgery, Dr. Abraham Aparicio, Bogota; Obstetrics, Dr. Joaquin Maldonado, Bogota; Gynecology and Abdominal Surgery, Dr. Jose M. Buendia, Bogota; Therapeutics, Dr. Manuel Plata Azuero, Guaduas; Anatomy, Dr. Joan D. Herrera, Bogota; Physiology, Dr. Antonio Bangas Vega, Bogota; Pathology, Dr. Nicolas Osorio, Bogota; Diseases of Children, Dr. Antonio Gomez Calvo, Bogota; Ophthalmology, Dr. Proto Gomez, Bogota; Laryngology and Rhinology, Dr. Luis Fonnegra, Bogota; Otology, Dr. Carlos Esguerra, Bogota; Dermatology, Dr. Daniel E. Coronado, Bogota; Orthopædics, Dr. Juan E. Manrique, Bogota; Naval Hygiene and Quarantine, Gabriel I. Castaneda, Bogota; General Hygiene and Demography, _____; Mental and Nervous Diseases, Dr. Pablo Garcia Medina, Bogota; Oral and Dental Surgery, Dr. Guillermo Vergas Parrdes, Bogota; Medical Pedagogics, Dr. Jorge Vargas, Bogota; Medical Jurisprudence, Leoncio Barrets, Bogota; Auxiliary Committee (each member being the official representative of the Congress in his respective city). Drs. Nicolas Osorio, Andres Posada Arango, Jorge E. Delgado, Eugenio de la Hoz, Domingo Cagiao, Jose Manuel Rodrigues, Paulo Emilio Villar, Felix M. Hernandez, Rafael Calvo, N. Ribon, Nilceades Castro, Cayefano Lombana, Jose M. Martinez, Isaias Saavedra, Severo Forres, N. Villa, Evaristo

Garcia, Miguel Caicedo, Emilio Villamizar.

The following medical societies have been elected as auxiliaries of the Congress, viz.: Academia Nacional de Medicina, Academia de Medicina de Medellin, Sociedad de Medicina del Canca. The following medical journals have been designated as official organs of the Congress, viz.: *Revista Médica*, Bogota; *Revista de Higiene*, Bogota; *El Agricultor*, Bogota; *Boletin de Medicina del Canca*, Cali; *Andes de la Academia de Medicina del Medellin*, Medellin. The expressed wish of the profession of the United States of Colombia is for a date of meeting during the Columbian Exposition.—CHAS. A. L. REED, Secretary-General. Cincinnati, January 17.

THE INTERNATIONAL EXECUTIVE COMMITTEE OF THE PAN-AMERICAN MEDICAL CONGRESS.—The Committee on Organization of the Pan-American Medical Congress at its meeting at St. Louis last October elected the following International Executive Committee: The Argentine Republic, Dr. Pedro Lagleyze, Buenos Ayres; Bolivia, Dr. Emelio Di Tomassi, La Paz; Brazil, Dr. Carlos Costa, Rio de Janeiro; British North America, Dr. Jas. F. W. Ross, Toronto; British West Indies, Dr. James A. De Wolf, Port of Spain; Chili, Dr. Moises Amaral, Santiago; United States of Colombia, Dr. P. M. Ibanez, Bogota; Costa Rica, Dr. Daniel Nunez, San José; Ecuador, Dr. Ricardo Cucional, Guayaquil; Guatemala, Dr. Jose Monteris, Guatemala Nueon; Haiti, Dr. D. Lamoshe, Port au Prince; Spanish Honduras, Dr. George Bernhardt, Tegucigalpa; Mexico, Dr. Tomas Noriega, City of Mexico; Nicaragua, Dr. J. I. Urtecho, Grenada; Peru, Dr. J. Casamira Ulloa, Lima; Salvador, Dr. David J. Guzman, San Salvador; Spanish West Indies, Dr. Juan Santos Fernandez, Havana; United States of America, Dr. A. Vander Veer, Albany; Uruguay, Jacinto De Leon, Monte Video; Venezuela, Dr. Elias Roderiguez, Caracas.

Hawaii, Paraguay, Santo Domingo, the Danish, Dutch, and French West Indies are not yet organized. Nominations of local officers have been received from a majority of all the members of the International Executive Committee, and a number of the lists have been confirmed by the Committee on Organization. These

will be announced as rapidly as acceptances are received.—CHARLES A. L. REED, Secretary-General. Cincinnati, January 15th, 1892.

ELEVENTH INTERNATIONAL MEDICAL CONGRESS.—At the recent Italian Congress of Internal Medicine, arrangements were inaugurated for the next International Medical Congress, which is to meet in Rome in 1893. The last two weeks in September would be the best time for the meeting. Baccelli has been made chairman of the Organizing Committee: Maragliano, general secretary. There will be twelve sections represented respectively as follows: Anatomy, Antonelli; Physiology, Albini and Albertoni; Pathology, Bizzozero and Foà; Pharmacology, Cervello; Clinical Medicine, Baccelli, Maragliano, Murri, and Bozzolo; Surgery, Bottini; Obstetrics, Morisani; Psychiatry, Morselli and Tamborini; Ophthalmology, Devincenzi and Secondi; Dermo-syphilopathy, Campana and Barduzzi; Forensic Medicine, Tamapia; Hygiene, Pagliani, Celli, and Canalis.

CORRECTION.—Hare's "System of Practical Therapeutics." It will be remembered that we gave a favorable review of Hare's admirable "System of Practical Therapeutics" in our issue of January 1st, in which we stated that the work was procurable from Messrs. J. A. Carveth & Co. We are requested by the publishers, Messrs. Lea Brothers & Co., to state that this is an error, and that the work is in the hands of Mr. D. T. McAinsh, of the Canada Life Building, Toronto.

MASONIC PHYSICIANS.—The Grand Lodge of Freemasons in England recently instituted the *Æsculapius* Lodge, composed of physicians. There has for some time been a lodge of apothecaries called the Galen Lodge.

THE *Buffalo Medical and Surgical Journal* says: It is to be deplored that so many excellent medical journals offend good taste by publishing interleaved advertisements.

A PHYSICIAN of Dakota has been sued for malpractice because, it is alleged, he caused the opium habit in a patient.