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CANADA
MEDICAL RECORD

JANUARY, 1901

Original Communications.

ODDS AND ENDS IN ORDINARY PRACTICE.

By A. D. Stevens, M.D., Dunham, Quebec.

THE DELUGE.

It is not intended by the above heading to frighten your readers into the belief that a flood of the old-time variety is upon us. The danger of such an infliction, if any, lies more in the number and quality of the drugs and new remedies the laboratory and other sources are thrusting upon a thankless world. Is it because we are all such sinners in the present age that history is repeating itself, or is it because the profession is ungrateful for blessings already received? No doubt some of them are here in the interests of the people of the healing art—that they are with us for future service and have come to stay, but who will venture to sift the wheat from the chaff; who possesses the courage to separate the sheep from the goats? Let us then rest and be thankful, saints that we all are you know, let us be assured of time and place to assimilate the mass. The commercial end of the arrangement may be safely trusted to take careof itself and the times and seasons are favorable to repose.

TUBERCULAR MENINGITIS.

No one who has had much to do with these cases has had his faith in the efficacy of medicine materially strengthened, or ever realized the dream that medicine is, or ever will be, an exact science. His reputation, his skill, his veracity, if based on no better foundation than promises or expectations of success in this stubborn and perverse phase

of tuberculosis, would be in danger of being put in question. However true this may be, the bad results that pursued me for so long in this business, if I am certain of my position, seem to have brightened up a little—appear to have turned in my favor at last. Formerly, that is previous to my treatment of the two little sufferers I am about to describe, the iodide of potassium (sometimes with a little simple bitter, and often without) formed the basis of my practice, but with terminations I have no special pride in relating. These two, although not occurring at the same time or in the same year, in fact, were treated precisely alike, and, to be fair, so far as I know, had no hereditary tendencies to consumption or evinced any symptoms that would point to deposits of tubercular matter elsewhere.

I had seen, heard or read somewhere that a cap or pouch, if you will excuse the word, made sufficiently large to cover the scalp and soaked or saturated with glycerine containing a generous dash of the tincture of iodine, promised advantages that were not to be despised or flippantly rejected. The cap was duly made, freely soaked or filled with the glycerine and iodine, applied to the scalp, and, with occasional renewals, kept in position for days. Internally the iodide of potassium was not, of course, left in the background, and, under it all, the children, not long after, began to mend, and *continued* to mend until relieved.

So far as the animal functions are concerned at least, the last time that I saw the children both had the appearance of perfect health; at the same time a close observer would, I think, be able to detect in the expression of their faces and eyes the fact that at some time or other there had been something wrong with their little brains.

All things considered, then, there is nothing to rule the treatment they received either impossible or impractical, but the question naturally arises: are their mental faculties liable to be weakened if they live to adult life, as they now bid fair to do? May we expect a return of the complaint in some other form or place?

INGUINAL HERNIA.

I remember, on a certain occasion, passing a whole

night with a woman suffering from an accident that I am led to believe is, more or less, of rare occurrence in the female—an unruly and persistent inguinal hernia. It was the first descent of the intestine, and tightly held in the grasp of the parts. Taxis, cold and other attentions were faithfully put in evidence, but, all the same, the rupture held full sway. The situation remained so obstinate and full of mischief that the only way out of it appeared to be through the knife. Now, I do not pretend to be much of a philosopher or a genius in expedients, but I had the faith to believe that the law of gravitation would, if used, prove as immutable and salutary in the premises as everywhere else—that it would hold as good in the case of an erring intestine as it did in the rest of the works of nature, and, as I am a humble believer in the benign influences of nature and nature's laws, the principle was seized upon and took root. A fresh looking woman of the soil, who had been showing great interest and sympathy in both the doctor and patient, was appealed to for help and yielded. Without much difficulty we raised the foot of the bed the patient was lying upon to an angle approaching ninety degrees, and firmly secured the supports.

In the course of half an hour or so the constricted portion of the bowel returned, bag and baggage, to its old home in the abdominal cavity in nearly as good condition as it left it hours before. The laws of gravitation, too, had once more, of a certainty, proved that circumstances do not change their habits or lessen their power and usefulness. There was no mistaking it; our troubles were well over, and it only remains to add that local and gastric attentions and a properly adjusted truss finished the business.

On three similar occasions of hernia since (all male) I have had the satisfaction of seeing this same law of gravitation prove itself as effective a factor or agent—an inflexible entity and faithful servant, but, in these instances, not much time or thought were wasted in taxis or other operations sometimes performed. The lower ends of the beds were elevated, as before, without ceremony, cold used each time, and, in due season, every one took its place in the orthodox way, the usual gurgle not excepted.

CLINICAL LECTURE.

DELIVERED AT THE MONTREAL GENERAL HOSPITAL, 5TH NOVEMBER, 1900.

By FRANCIS WAYLAND CAMPBELL, M.A., M.D., C.M., L.R.C.P.L., D.C.L.

Dean of and Professor of Medicine, Faculty of Medicine, University of Bishop's College, Montreal.

INFANTILE CONVULSIONS.

I have had considerable experience during the last thirty years with medical students, and I am inclined to believe that he does not always have impressed on his mind the importance of convulsive seizures in infancy and childhood. Perhaps there is nothing that will go farther toward establishing the reputation of a physician than being able to show that you are master of the situation—that you thoroughly understand the principles of the treatment of convulsions. The truth is that the reputation of the physician is more likely to be established by the successful management of what may be called minor diseases than by severe and complicated diseases. The fact is, the young physician rarely gets a chance in the management of grave disease. As convulsions occur suddenly, and generally without warning, the family physician impossible to be found, the young doctor, sitting in his office waiting like Micawber for something to turn up, finds himself called to fill an emergency. He will generally find the mother or the nurse, and possibly both, have lost their head. His arrival on the scene will be hailed with expressions of satisfaction, and his management of the case will show his ability or otherwise. If he knows his work, he will then and there lay the foundation of future success.

Convulsions may occur within a few days of birth, and then are due to some injury of the brain, occuring during the labor. They may be general or involve only half the body. Two weeks from birth they usually cease. From that till six months infants are usually free from them, but onwards till the seventh year they are not uncommon. The onset of structural disease of the brain or its membranes may be attended with general convulsions. With this exception the etiology of infantile convulsions is obscure. At birth the de-

velopment of the nervous system is not complete, and its functions are not fully organized till a later date. The lower centres are organized earlier than the higher, and it is supposed that, wanting effectual inhibitory control from above, they are more prone to excessive action in response to peripheral stimuli. Very often the child is rickety, and there is a neurotic family history. It may be impossible to discover the cause of infantile convulsions. Very often they are toxic, and such cases are met with at the onset of scarlatina and measles. In my experience they are most frequently met with as the result of peripheral irritation caused by indigestible food, often from dentition. Occasionally, the cause is worms, or otitis, the result of scarlatina. There is a condition, which you will often be called upon to treat, which among the public is designated "inward fits" or silent convulsions, the latter somewhat a misnomer, as convulsion means movement. In these cases the infant lies as if asleep, but rolls his eyes, groans, the muscles of the face are drawn, and very often there is a bluish ring around the mouth. Such cases are always the result of over-feeding, and requires prompt attention to the child's diet. The immediate attack should be treated by one to three drops, in water, of compound spirits of ether or aromatic spirits of ammonia, every half hour, for a half day, when most likely there will be no recurrence.

When the true convulsion comes on it is generally unexpectedly. The muscles of the body become stiff and immovable, the muscles of the face twitch, the lips are drawn in varying directions, the eyes prominent and fixed, the pupils are contracted, the face is generally congested, the respiration labored, and the number less than normal; the pulse is rapid and small, the hands clenched, with thumb turned in. During a seizure, urine and feces are often passed involuntarily. The duration of the convulsion is variable, but I have seldom seen them last more than two or three minutes. To those immediately related to the little sufferer, even such a brief period seems ten times longer than it usually is, and, on arriving on the scene, as a rule you will, in consequence of this, be given an exaggerated account of the duration. The

child may, however, it must be remembered, pass from one convulsion into another with a very brief interval. These cases, I need hardly say, are very serious, for the child may become comatose, and death ensue in a few hours. Still, even these severe cases do sometimes recover, so never despair. Set about your duty hopefully, and success may even in apparently desperate cases be the result. After the convulsion has passed off, the face gradually assumes its normal appearance, and the child goes into a placid slumber, with a gentle perspiration covering its body. It is important to remember that often only a part of the body is affected. For instance, one side of the body or the arms, or only the face, may show convulsive movement. As regards the treatment, much can be done, and I shall give you my experience instead of that which you can find in any treatise on infantile diseases. As in your early professional life your practice will mainly be among the poor, if you arrive on the scene when the child is in the throes of the convulsion, as I hope you will, whether it be the first or second seizure, you will find the cradle or bed surrounded by every old woman of the neighborhood. Loose no time in ordering these officious women to "get out," thereby allowing free access of air to the little patient. Then give a chloroform inhalation, with a view of cutting short the fit. Chloroform is, I might say, almost, if not perfectly safe, as an inhalation in children. When the convulsion has ceased place the child in a bath, temp. 92° to 94°, sponge the head with cold water; occasionally, when I think the case requires stimulation, mustard is added, 1 ounce of mustard to each gallon of water, at a temp of 98° to 106°. To a child of a year and upwards I do not hesitate to give ten grains of calomel. This will give as a rule. not more than four or five copious motions. If, however, I think it desirable to have immediate action, I give an enema of warm soap suds, to which is added a small quantity of olive oil warmed. I then place the patient on a mixture of which the following is a sample, for a child one year old: ℞ Pot. Bromid, ʒiss; Chloral Hydrate, gr. viii; Tinct. Aconite (F) gtts. xvi; Syr. Simp. ʒi, Aq. ad ʒiv. Sig. ʒi—every 4 hours. Sometimes if the convulsion is repeated in a child old enough to be fed from the family table, I often find that it has had

what is called mashed potatoes, which in my experience often contain big lumps. In such cases it is advisable to empty the stomach at once, and I find in dried alum an excellent emetic, a half to one teaspoonful dissolved in water. If the convulsion be due to dentition, and I find the mucus membrane of the gum stretched by a tooth near the surface, I do not hesitate to use the gum lancet and cut right down to the tooth. In cases which occur after the age of a year the child should be put on tonics, of which the Elixir of Calisaya Bark or the double Syrup of Iodide of Iron and Quinine (Campbell's) are good examples. It should live largely in the open air, and during summer should be taken to the seaside, and be sponged every morning with hot sea water. If this cannot be done, then it should have the same kind of bath at home. Sea salt can be purchased at any chemists. Children who have had convulsions in early life should not be sent to school too soon. If they indicate precosity their education must be carefully watched. If it is pressed, brain trouble will often supervene, terminating in death, or in a pseudo-epilepsy, which with advancing years may develop into true epilepsy the horrors of which can only be known to those who have one in their own family.

Since Dr. Campbell insisted upon having children admitted to his Clinic, instead of being shunted off to the Children's Clinic, a department not officially recognized by the Hospital authorities, there has been a very large influx of the little ones. Diarrhœa has been the complaint of the majority, but a few cases of marked constipation have been met with. Strange to say, this condition seems to cause little concern to the majority of mothers. Dr. Campbell says it is met with mostly among bottle fed children, whose diet lacks sufficient fatty elements, but it is met with even when the child is nursed by a healthy mother. Mothers are too apt to employ castor oil, which only gives temporary relief. Drugs are as a rule best avoided. If a breast-fed child, the milk should be examined. If there is excess of proteids, then the mother ought to take more active exercise, and this element in diet should be diminished. If the constipation is in a baby fed with the bottle, then, if deficient in fats, this

should be brought up to 4 per cent. at least. This may be done by adding cream to the food. An excellent method of attaining this end is to give to a child three months old a drachm of fresh sweet butter; a little more to older children. For a couple of weeks this should be given three times a day; then on alternate days; then once a week. The result is generally very satisfactory. It is highly recommended by German physicians. Injections and suppositions are like medicine, objectionable, as their use soon induces a habit. The bowel, accustomed to act only on rectal irritation, very soon learns to await it, and fails to yield to the milder irritation caused by the presence of fecal matter in the lower colon and rectum. When the child is older—say from a year to two years—gruel may be tried, at the same time using gentle massage of the bowel, and subsequently rubbing in either butter or the best salad oil.

Pediatric specialists, Dr. Campbell says, are some of them preaching the doctrine that "teething produces nothing but teeth," which he from long experience believes to be nonsensical. It is true that some children pass through the teething period with but little, if any, discomfort. This, he believes, was due to two reasons: 1st, the character of the gingival tissue, which in some is dense and unyielding; 2nd, the nervous system, although generally exalted in children, but more so in some than in others. Any one—whose practice has been a family one—knows that teething is generally painful. From the moment that the growing teeth begin to form, or very soon after, they press on the gums and give rise to no end of symptoms of nervous irritation. Dr. Campbell said he had seen all these symptoms disappear, on the gum over the pressing tooth being incised with a gum lancet, an instrument which he believed was not used often enough. This fact has been repeatedly exemplified at this Clinic. All know there are certain pains which are relieved by pressure, and pain in the gums of a child would seem to be of this kind. They seize hold of everything hard and place it in the mouth and chew it. This desire of nature is utilized by what is called "a chewing ring." It is made of hard or soft rubber—the former is best, but better still is one made of

celluloid. It has the advantage of being easily cleaned, and in my experience infants like it best. It is good practice to bathe the gums either with plain warm water or a little bromide of potassium added to it. The bathing is best done by the finger dipped into the water and then rubbed over the congested gums. Teething children are unquestionably thirsty, and their thirst is not relieved by their liquid food; he constantly gives a teaspoonful or two of ordinary cold water several times daily, and is satisfied it does good.

Selected Articles.

THE TEMPERATURE OF BATHS IN TYPHOID FEVER.

The treatment of baths in typhoid fever should be regulated so as to obviate the dread which the patient experiences. To the family as well as the nurse and the physician it is often heart-rending to see the piteous expression of the patient when his bath is prepared. If the patient is only semi-conscious his terrible shrieks and struggles are not only pitiful, but are often likely to cause interference from the side of the family. Besides, the excitement accompanying or preceding the bath nearly altogether counteracts what good effect is aimed at, by the shock of the cold bath on the nervous system and the temperature.

When resorting to the tub bath in typhoid fever, it should be the aim to make the bath seem a pleasant remedy to the patient. This is best achieved by never placing the patient into water lower than ninety-eight degrees. This temperature alone is sufficient to reduce the fever temperature, especially if at the same time colder water is poured upon the patient's head. The reduction of temperature of the bath can easily be accomplished by placing ice into the water so that at the end of thirty minutes, when the patient is removed, the water is as low as eighty-five degrees. It is questionable whether a lower temperature is of any benefit whatsoever. If we take into consideration the difference in the looks of patients treated with a bath varying from ninety-eight degrees to eighty-five degrees, and, on the

other hand, from eighty-five degrees to seventy-five degrees, we easily arrive at a conclusion in favor of the former. The patient has not the anxious look, the agonized expression, the blue lips or the constant shiver which we are wont to see in the latter cases. The reduction of the fever temperature is achieved in both cases alike, perhaps a little faster in the colder bath, but certainly not with the same feeling of comfort and—if we may use the expression—of "well-being." The warmer bath seems also less harsh, and will, in private cases, not meet with such frequent opposition as will the colder one.

As regards the management of the bath, it is well to bear in mind a few particulars adding to the safety of the patient when lifted in and out of the tub, and to his comfort while in the tub. In hospitals and in private practice, the physicians and attendants, who use the greatest possible care in turning a patient from side to side or in lifting up his head for the administration of food, will frequently not hesitate in picking the patient up by his shoulders and legs to place him into the bath. This is dangerous practice, not to speak at all of its unæsthetic aspect. By raising a patient thus unceremoniously his abdomen is not well taken care of. The voluntary or involuntary contraction of the abdominal muscles during such a proceeding press upon the distended intestines and disturb the rest in which even the pathological distention has placed them; at least, irritation of the diseased organ, if not breaking of an ulcerated surface with consequent bleeding, is likely to follow, and the supposed remedy to prove an aggravating factor. A good way to lift the patient into the tub is to place him upon a large sheet in the centre of which six or eight large buttonhole-like perforations have been made. He is placed in the bath on this sheet and it is left under him. When raised out of the bath he is in the net of the sheet, the water running out of the centre holes. The patient can be moved this way at an indefinitely greater comfort and safety to himself and also to the attendants. To increase the comfort and safety of the patient while in the bath he should receive a moderate dose of brandy at the beginning of the bath, and should be gently rubbed with some coarse material, a rough sponge or a coarse drawn linen towel. This rubbing of his back, chest and limbs must be kept up while the patient is submerged. His abdomen should be carefully avoided. After his removal from the bath he receives a warm glass of milk with lime water, and is covered with light woolen blankets. It is not advisable to give any brandy, as the cooling effect of the bath is counteracted to a large extent by stimulants.

A SIMPLE AND EFFECTIVE TREATMENT FOR DYSPEPSIA.

By J. M. McLEOD, M.D.,
Professor of Surgery in the Lincoln Medical College, Surgeon to Lincoln City Hospital, Lincoln, Neb.

The first broad and universally conceded principle applicable to maldigestion is that a constant and essential feature of the condition is a lack of ability on the part of the digestive organs to properly perform their functions; this fact is equally true of acute dyspepsia, chronic gastric catarrh and the various forms of so-called amylaceous or starchy dyspepsia. In most cases the causative element is a defective and deficient secretion of the digestive ferments; this, in turn, gives rise to a whole train of symptoms, which we recognize clinically as dyspepsia. This lack of digestive ability is an unmistakable and imperative indication for artificial aid—to supply those working principles by which foodstuffs are converted into the end proteids of digestion. This fact, which may be termed an axiom, stands out prominently in every scientific treatise upon dyspepsia. The great question, however, is: how can artificial digestion be best accomplished? That pepsin, pancreatin and the various diastasic ferments fail in this respect will be acknowledged by everyone of experience; their field of usefulness is at best an exceedingly limited one, and may be characterized as unreliable. It is interesting to note, in this connection, the recent results obtained by Prof. Reynolds Green, the well-known English physiological chemist, who found that pepsin does not, in itself, effect the digestion of albuminoids into peptones, but that it is merely an initiatory step, which is completed by the pancreatic ferments in the intestines. Other well-known facts concerning pepsin and pancreatin throw additional light on the subject of why these are clinically ineffective. For instance, pepsin requires a strongly-acid medium, else it is inert. Pancreatin is likewise inert in an alkaline medium. Furthermore, neither ferment is strong in its digestive power. As is well known, the gastric contents in the various forms of dyspepsia are sometimes acid, sometimes alkaline. In other words, the pathological conditions in dyspepsia call for the exercise of properties which pepsin, pancreatin and the diastasic ferments do not possess. Another reason for the limited value of the above ferments is that the subjective symptoms of dyspepsia imperatively demand the administration of palliative remedies for relief, and many of these remedies destroy the physiological activity of pepsin, pancreatin, etc. An ideal ferment must possess the properties of digesting all classes of foodstuff as represent

ed in an ordinary diet, and, most important, must exercise its activity absolutely independent of chemical conditions existing in the stomach. Furthermore, it is necessary that such a digestive ferment preserve its power when administered conjunctively with the various antiseptics, astringents, bitter tonics, etc., without the aid of which there can be no successful treatment of dyspepsia. Most interesting in this connection is the published report of Professor Chittenden, of Yale, regarding vegetable ferments, showing that "caroid," the soluble digestive ferment derived from *Carica papaya*, possesses the following characteristics:—

1. It is a true soluble digestive ferment of vegetable origin.

2. It has marked proteolytic action in acid, alkaline and neutral solutions and in the presence of many chemicals, antiseptics and therapeutic agents.

3. It has a peculiar softening and disintegrating action on proteids, and its general proteolytic action is that of a genuine digestive ferment, similar to the ferments of animal origin.

4. It has amylolytic, or starch-dissolving, power.

5. It has a marked rennet-like action upon milk and a pronounced digestive action upon milk casein.

6. It exerts its peculiar digestive power at a wide range of temperatures.

7. The ordinary conditions of health and disease in the stomach and intestines are not likely to check its action, while certain possible conditions may accelerate it.

Here we have an agent that in action differs widely from the digestive ferments of animal origin, and one that, on theoretical grounds, perfectly fulfills the requirements of artificial digestion. I have been convinced by an extensive clinical experience, embracing several hundred cases, not only that it also practically fulfills these requirements, but that caroid is by far the most valuable single agent we have for the treatment of dyspepsia. Particularly gratifying is the fact that the symptoms of the disorder will yield to the administration of appropriate remedies when used in conjunction with caroid, which, without this latter agent, partially or completely fail. Although, previous to the use of this digestive, I had resorted to the examination of the stomach contents in almost every case as a routine practice, in order to determine in what elements and how far the digestive powers of the stomach were impaired, I now reserve this procedure for certain rare cases in which there are special reasons for knowing the exact chemical and other conditions existing in the stomach. The results obtained are extremely satisfac-

tory, and the saving of a great amount of time is, in itself, a strong commendation.

In regard to diet, the character of the patient should be first considered, and, if a restricted diet will be observed, it should be required. On the other hand, if satisfied that a strict diet will not be observed, it is better to prescribe only such general rules as the patient will probably follow, such as regular meals, proper mastication, the avoidance of all coarse, overstimulating and improperly-cooked foods, and especially the avoidance of those foods to which troublesome symptoms can be ascribed. It is seldom necessary to bar tea or coffee unless their use has been excessive.

The most common class of cases—those ordinarily designated chronic dyspepsia or chronic gastric catarrh—are, according to the usual methods of treatment, difficult to manage even upon a semblance of routine plan. These patients—whose complaints are so well known that it is almost superfluous to mention them—present symptoms soon after eating. There is pain and a sensation of fullness in the region of the stomach, with evidences of slow digestion and acid eructations. Flatulence, constipation, capricious appetite, nausea and vomiting are present with varying degrees of frequency. Except when special symptoms are particularly accentuated and call for the administration of special correctives, these cases may be satisfactorily treated by either of the following combinations now offered in the form of tablets:—

1. Caroid, gr. j.
   Charcoal, gr. iss.
   Boric acid, gr. iss.
   Sacch. lac.,
   Pulv. arom., q. s.

2. Caroid, gr. j.
   Soda bicarb., gr. iij.
   Menth. pip.,
   Sacch., lac., q. s.

If fermentation and excessive acidity are especially pronounced, caroid may be judiciously combined with creosote, in 3-grain doses, thymol, bismuth or larger doses of sodium bicarbonate, according to individual requirements. In atonic dyspepsia, characterized by loss of appetite and the inability to digest food, a combination of caroid with the usually-employed bitter tonics—nux vomica, quassia, gentian, etc.—affords surprisingly quick relief, and in most cases permanent cure.

It is not my object, in presenting this paper, to offer a

systematic treatise upon the treatment of dyspepsia, but merely to emphasize the fact that this condition can, according to the above general principles, be satisfactorily treated by the average general practitioner, who has neither the time nor the laboratory training and equipment to study scientifically the exact chemical and pathological conditions existing in the stomach. As above mentioned, it is a simple and effective method which has proved invariably satisfactory after three years' extensive employment.—*Med. and Surg.*

THE LIGHT TREATMENT AT THE LONDON HOSPITAL.

By J. H. SEQUEIRA, M.D., M.R.C.P., of London, England.

Dermatological Assistant and Medical Officer in Charge of the Light Department of the London Hospital.

On the 29th of May, 1900, a department was opened at the London Hospital for the treatment, by light, of lupus and other superficial cutaneous diseases which depend upon bacterial infection. The method employed is that devised by Professor Finsen, of Copenhagen, and first described by him in 1897. For over three years it has been carried out in a special institution in the Danish capital with conspicuous success, patients being attracted from all parts of northern Europe and even from England. The royal family of Denmark have taken a very great interest in the Finsen Light Institute, and the apparatus now in use at the London Hospital is the gift of H.R.H. the Princess of Wales.

The principles upon which the treatment is based are the following:

1. Light is a germicide. This fact was first established in 1878 by the classical researches of Downes and Blunt, and it has since been the subject of investigation by Duclaux, Arloing and many other workers. It has been shown that the bactericidal action of light is due to the violet and ultra-violet rays—the so-called "chemical" rays of the spectrum. Plate cultures of many micro-organisms are killed if exposed to their action for a sufficient length of time. But it is obvious that, if the chemical rays of sunlight were strong enough to destroy the microbes in the skin under ordinary circumstances, lupus and those diseases which depend upon bacterial infection would disappear during the summer months. Dr. Finsen, however, found that the bactericidal action of the

chemical rays is enormously increased if the light is concentrated by means of lenses, and especially by lenses made of rock crystal, which allow the ultra violet rays, which are in part absorbed by ordinary glass, to pass through. In his apparatus the red rays of the solar spectrum are absorbed by making the light pass through a blue medium, while the ultra-red or purely calorific rays are absorbed by a layer of water. Some of the earlier workers in this field endeavored to treat lupus by means of "burning glasses," and by mirrors, but it will be easily seen that, as they relied chiefly upon the heat rays, such a concentration, if carried out for a sufficient length of time, would inevitably cause combustion of the tissues.

The ordinary artificial lights, including the incandescent electric light, are useless as bactericidal agents, as they contain very few chemical rays. The electric arc lamp, on the other hand, gives a light which is rich in these rays, and, if the light be of great intensity, the germicide action is greater than that of the sun itself. The electric light is, of course, expensive, but if cases of lupus are to be treated by light in northern latitudes, it is impossible to depend upon the sun for the greater part of the year.

2. The chemical rays of light have an irritant effect upon the skin. The commonest example of this is the form of dermatitis, known as erythema solare, some of the best instances of which are seen in the tourists on the glaciers, and in the explorers of the arctic regions. A similar inflammation is met with in the workmen employed in the blast furnaces which are worked by electricity. As Maklakow has shown, the inflammation set up by the very strong electric light which is developed in these furnaces is much more intense than the similar affection produced by strong sunlight. Professor Widmark, of Stockholm, has proved that in both instances the dermatitis is due to the chemical rays, and is independent of the heat rays; in other words, that it is not a burn. The effects produced by the chemical rays and the heat rays differ in very important particulars. The effects of a burn are immediate, whereas those of the chemical rays of light are only manifested after the lapse of some hours. As a rule, the inflammation does not reach its maximum until after from twelve to twenty-four hours. It has long been recognized by dermatologists that cases of lupus often show remarkable improvement after attacks of superficial inflammation, such as erysipelas. This is probably due in part to the effects of the local inflammation upon the bacteria in the affected tissue, but the influence of the inflammatory process upon the lupus tissue itself cannot be left out of consideration.

3. Light has a certain penetrative power. This is, of course, in no way comparable with that of the Röentgen rays, but it is sufficient to blacken chloride of silver placed in sealed tubes under the skin of animals. Professor Finsen has further shown that this power of penetration is much greater when the skin is anæmic. He demonstrates this by placing a piece of sensitive photographic paper behind the lobule of the ear, and then exposing the outer surface of the auricle to the light. In its normal condition the paper is blackened at the end of about five minutes. If now the experiment is tried with the ear rendered exsanguine by compressing it between two pieces of glass, the same effect is produced in twenty seconds.

A consideration of these facts shows that, to carry out the treatment of lupus and similar diseases by light, a lens or system of lenses is first required to concentrate the rays. These lenses are preferably made of rock crystal, so that the whole of the ultra-violet rays may be brought to a focus. Secondly, the red and ultra-red rays must be absorbed by passing the light through suitable media. Lastly, there must be an apparatus to compress the skin and render it anæmic.

The installation at the London Hospital has been carried out upon the lines suggested by Dr. Stephen Mackenzie in his report upon the Finsen Light Institute at Copenhagen. Two sets of apparatus are in use: one for sunlight and one for the electric light.

The sun's rays are concentrated by means of a hollow planoconvex lens ten inches in diameter. The cavity of the lens is filled with an ammoniacal solution of sulphate of copper. The lens is attached to a strong metal support in the form of a fork, in such a manner that it may be turned about a horizontal and also about a vertical axis. The fork is attached to a rod, which can be raised and lowered at will. The stand is placed upon a table about three feet high, and the patient lying upon a couch or sitting in a light rocking-chair is put in such a position that the area of skin to be treated is at the focus of the lens. The light rocking-chairs are used, as they can be placed at different angles and fixed by wooden blocks. As it is found in practice that the copper sulphate solution does not entirely absorb the heat rays, the compression apparatus is made to serve also as a cooling medium. It consists of a flat cell, made of two pieces of glass or rock crystal fixed in a metal ring. Attached to the margins of the ring are four projections, to which elastic bands can be fastened. By means of these pressure is brought to bear upon the part under treatment. In certain

situations it is found to be more convenient to dispense with the elastic bands, and to press the glass upon the skin with the fingers. In any case, the pressure-glass must be held by a nurse, as it is essential that the light should fall perpendicular upon its upper surface, and that the area under treatment should be in focus. Two metal tubes are fitted into the pressure-glass, and they are connected by India rubber tubing with a water-supply, and a constant stream of cold water is passed through the apparatus and keeps the skin cool.

To carry out this treatment a portion of the hospital garden has been set apart, and during working hours this is enclosed by a canvas screen.

Apart from considerations of expense, the sunlight treatment has the great advantage of keeping the patients out in the sun during the *séance*, and this has an important influence upon the general health.

As has already been indicated, a very powerful arc light is required, and that in the installation at the London Hospital is of over 30,000 candle-power. To obtain a light of such intensity it was necessary to introduce a transformer, as the current supplied to the hospital from the public mains has a voltage of 480 and an amperage of 10. By means of the transformer a current of from 50 to 80 amperes is supplied, and this produces a light of requisite strength. In practice the lamp is usually worked at from 50 to 65 amperes. The lamp is suspended from the roof of a large room, which has been cut off from one of the temporary wards by a partition. As will be seen from the accompanying illustration, the lamp itself is surrounded by a metal screen, which serves as a shade, and at the same time excludes draughts. Attached to a strong metal ring at a lower level are four telescopes. Each is made of two parts, one sliding within the other. The lenses of the telescopes are made of rock crystal for the reasons mentioned above. The rays of the electric light are divergent, and the lenses of the upper piece of the telescope render these diverging rays parallel. The second piece brings these parallel rays to a focus about six inches below the lowest lens. The lower piece of the telescope is filled with distilled water to absorb the heat rays, and is kept cool by a water-jacket, very similar to that of the Maxim gun. Through the jacket a stream of ordinary tap-water flows continuously, and this is conducted by an India rubber tube to the pressure-glass, which is used in precisely the same manner as in the treatment by sunlight. The patient is placed upon a couch or rocking-chair and focused to the light. The area of skin to be treated, after being cleansed with an antiseptic solution, is marked with a dermatographic pencil.

From one to three square centimeters are exposed daily for an hour to the action of the light. Then another area is treated, and this is continued until the whole of the affected part has been submitted to the rays. If at this point the existence of suspicious spots is noticed, these are again treated.

At the present time there is one lamp, and only four patients can be treated at each *séance*. The demands upon the department have already become so great that two more lamps will probably soon be erected. Each patient is attended throughout the *séance* by a nurse, whose duty it is to regulate the pressure apparatus. The nurses are under the charge of sisters who have been specially trained for the work in Copenhagen. They wear overalls, and their eyes are protected by smoked glasses. Care has to be taken in treating lupus of the face that the patient's eyes are similarly protected; and if the disease is near the orbit, the eyes are covered with lint soaked in water, and over this a layer of brown paper is placed.

At the end of each *séance* there is an interval of a quarter of an hour, during which the dressings are applied, and the nurses cleanse the pressure glasses with carbolic lotion and spirit, and wash their hands and forearms in an antiseptic solution.

The local effect of the treatment is the induction of an inflammation of moderate intensity. The more recent and less pigmented cases react the more strongly. Redness, swelling, and, in some cases, slight vesication are present in from twelve to twenty-four hours after the *séance*. Under the influence of a simple soothing dressing this soon subsides, and the area becomes flatter, paler and smoother. The treatment is painless; there is no pyrexia and practically no scarring. The advantages over treatment by scraping, burning by acids, etc., etc., are obvious. Ulcerating surfaces have to be treated upon general principles until the pressure-glass can be borne. It is, unfortunately, impossible to submit lupus of the mucous membranes to the action of the concentrated chemical rays in this manner. For these, however, the X-rays are employed.

It is as yet too early to say anything about results in the cases which are under treatment at the London Hospital, as the department has been open for so short a time. Cases of from four months' to sixty years' duration are under treatment, and, provisionally, it may be remarked that the results so far are in every way comparable with those seen by the writer at the Finsen Light Institute in Copenhagen. It may be worth mentioning here that some of the Danish cases have been free from recurrence for a period of two years.

The light treatment has been tried in cases of lupus erythematosus, but the results are not nearly so striking as in lupus vulgaris. Dr. Finsen finds that about a third of the cases show signs of improvement. In alopecia areata the results are very encouraging, and in a recent paper ("Hospitalstidende," Nr. 13, 1900) Dr. Finsen describes cases of epithelioma of the skin which have been greatly benefited by the light treatment. Rodent ulcer is difficult to treat owing to the fact that in advanced cases it is often impossible to submit the part to the pressure which is requisite.

Progress of Medical Science.

MEDICINE AND NEUROLOGY

IN CHARGE OF

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ASTHMA.

Very little is known of the action of iodide of potash in this disease, but undoubted it is that the action is a highly beneficial one. After all the ætiological factors have been considered and the attack persists, the practitioner will find that large, nearly heroic, doses of kali iodatum will not only cause amelioration, but cure many cases of asthma. Kali iodatum is recommended in all text-books of medicine and therapeutics in doses of five to ten grains every three hours. The effect of such administration is a double one—firstly, it fails to influence the disease sufficiently to make the patient persist in its use; secondly, it is soon followed by bad gastric and skin symptoms. The alterative effect of the salt, its antispasmodic and vaso-dilating action is nearly of immediate benefit in asthma when given in adequate doses. The first effect, and the subsequent freedom from attacks, without the supervention of disagreeable stomach or skin symptoms, usually cause the patient to persist with the medication, and excellent results are obtainable. Above all, in asthma, it is necessary to give immediate relief, and to stop any irritation which is present. While even here the iodide of sodium or potassium will suffice, it is best and safest to give a full dose of morphia or codeine, per os or hypodermically (according to the severity), to allay the attack. The potassium treatment is

then instituted. The patient begins with thirty drops of the solution saturata kali iodati in a tablespoonful of water, followed immediately by a glassful of water, milk or seltzer. The dose is given fifteen minutes before meals, or immediately after each meal. All starch-containing food must be avoided in the latter case. Each day the dose is increased by five drops until teaspoonful doses are taken, when it is similarly reduced back to thirty drops. During the first week of the treatment a solution containing one-eighth grain of morphine or one-fourth grain of codeine is given every four to six hours. A good prescription is the following:

℞	Morphia sulph., gr. ij. or codeinæ sulph.	gr. iv
	Spt. ammonii arom.....	℥ ss
	Spt. chloroformi.....	ʒ ij
	Aqua dest.....	ʒ x

M. Sig. Teaspoonful as directed.

The potassium iodide can be continued this way for six to eight weeks, while during the time of its administration a tablespoonful of Epsom salts are ordered every morning or every alternate morning, taken in a glassful of hot water before breakfast.

THE JUSTUS BLOOD TEST FOR SYPHILIS.

By Dr. Jones (*New York Medical Journal; Post Graduate.*)

This test was first described by Justus in 1895, and later elaborated by him in 1897. The only confirmatory report published since that date was by Cabot and Mertins in 1899.

The test depends on the asserted fact that a single inunction of mercury causes a reduction of from 10 to 20 per cent. in the hemoglobin in about 24 hours in all untreated cases of secondary, tertiary and congenital forms of syphilis. Justus says that the reduction also follows intravenous and subcutaneous injections, but that the administration of the drug by the mouth has no effect on the blood. The latter authority obtained positive results in more than 300 cases of syphilis. The test was negative in a large series of non-syphilitic cases. Cabot has partially confirmed the results obtained by Justus, although he observed the reaction in two non-syphilitic patients—one a case of tertian malaria and the other a patient with chlorosis.

The test was also obtained by Justus in 13 out of 16 cases in which only a fresh chancre and inguinal adenitis were present. Both Justus and Cabot agree that the so-

called "latent" cases and those which are subsiding either spontaneously or under treatment do not respond to the test.

During the last six months Jones has tried the test in 53 cases, 35 of which were leuetic, the other 18 being controls. In 18 cases of active syphilis not under treatment, 13 were positive and 5 negative. In 2 latent cases the test was negative. In 8 cases of chancre with adenitis, 2 were positive and 4 negative. In 7 cases of chancre without adenitis only 1 case was positive.

The control cases included 5 cases of phthisis, 1 of typhoid fever, 1 of apoplexy, 1 of fractured rib, 1 Colles' fracture, 1 drug habit, 1 of charcroid and 7 of acute alcoholism. All of these were negative. The author used Hammerschlag's and von Fleischl's methods to estimate the hemoglobin. As a result of his experience Jones concludes that the test is of value in the recognition of doubtful cases of syphilis, although it is not infallible. Further, the test often fails in latent cases and in early chancre, and sometimes at the beginning of the secondary stage. He thinks the reaction is of about the same value in syphilis as the diazo-reaction is in typhoid—*i. e.*, its presence in association with other suspicious symptoms is of great value, whereas its absence does not by any means indicate that the disease does not exist.

CLINICAL LECTURE ON HÆMATURIA. (*a*)

By JOHN H. BRYANT, M.D. Lond., M.R.C.P.

Assistant Physician to Guy's Hospital.

In the course of a clinical lecture, delivered at Guy's Hospital, on a case of hæmaturia, in arriving at a satisfactory diagnosis the author recapitulated the many causes from which this condition may arise. The case upon which the attention of the class was centred was that of a young healthy woman, æt. 21, in whom hæmaturia had come on suddenly after a severe shock to the nervous system. There were no important symptoms or physical signs, the blood was mixed with the urine and appeared to have come from the kidney or the pelvis of that organ. The urine was carefully analysed, and it was found that blood was the only abnormal constituent. A thorough physical examination was made, but revealed nothing abnormal. She was discharged from hospital apparently well, but twelve days after she returned and remained forty-three days; she had pyrexia

(*a*) Abstract of Clinical Lecture delivered at Guy's Hospital.

for a month, the temperature running a course very like that of typhoid fever. The patient was a married woman who had had one child, labour having been easy with no bad symptoms following it. The most important symptom of disease appeared to be blood in the urine, and the first consideration was to determine whether the case was one of hæmaturia or hæmoglobinuria. The large number of blood corpuscles found in the urine made it quite certain that it was hæmaturia and not hæmoglobinuria. It then became necessary to attempt to determine the cause of the hæmaturia, which might be due to a large number of causes:—*i.e.*, morbid changes in the kidney, pelvis, ureter, bladder, urethra, or blood. Blood from the kidney was usually intimately mixed with the urine, so that it presented a uniform color; blood from the bladder might also be intimately mixed with the urine, but often the first urine passed was quite clear, the blood appearing towards the end of micturition; blood from the urethra was either passed at the beginning or at the end of micturition, and the quantity was usually small. The blood in the case under discussion was intimately mixed with the urine, indicating the kidney or pelvis as the seat of hæmorrhage. The patient was not menstruating, and there was no evidence of uterine fibroids, uterine carcinoma or malingering. There was no evidence of *active congestion* as the result of a chill or acute febrile disease, and none of any noxious drug used internally or externally. There were no physical signs or symptoms of heart or lung disease, so *passive congestion* was put out of court. There was no evidence of *acute nephritis*, the urine being neither scanty, of high specific gravity, nor largely albuminous. Chronic tubal nephritis, chronic intestinal nephritis, suppurative nephritis, calculi, embolism, tubercle, carcinoma, sarcoma, cystic disease, movable kidney, injury, parasites, pyelitis, aneurism, were in turn discussed, but were eventually all dismissed as not fitting the case under consideration. There was no other indication of hæmorrhage beyond the hæmaturia. There was no family history of hæmophilia, the spleen was not enlarged, there was no purpuric eruption, there was no anemia, and there was also no reason to suppose it was due to any of the acute fevers; therefore, the only deduction was that the case was one of bleeding from a healthy kidney. The late Dr. Moxon was much interested in this condition, and used to compare it to epistaxis, arguing that, if epistaxis occur without any obvious organic change in the nasal mucous membrane, why should not hæmorrhage arise from the kidney in a similar manner. It had long been recognised that renal hæmaturia might occur without any obvious morbid

change in the kidneys and unconnected with any general disease such as purpura, hæmophilia, etc. Many surgeons had doubtless operated for hæmaturia expecting to find calculus or some other morbid change, and had found nothing to account in a satisfactory way for the hæmaturia. A curious feature in cases of this nature was that after exploratory nephrotomy or pyelotomy the hæmaturia often ceased. Mr. Harry Fenwick (*b*) had reported two cases of a similar kind, one was a young girl who had suffered from intermittent hæmaturia for five years, the attacks coming on suddenly when she was in good health. Operation was performed, the pelvis being carefully incised and examined, and what appeared to be a villous tumour of a papilla was found and removed. Subsequently it was examined microscopically, and it was suggested that it might be an early stage of fibromatous condition. The second case was a lady, aged thirty, in whom hæmaturia had commenced fourteen days before without apparent cause. On operation a "bright red varicosed papilla was found," which examined microscopically showed nothing beyond distended blood vessels and extravasation of blood. These two cases were to be regarded as of great importance, and Mr. Harry Fenwick's deductions were that in at least some of these cases the bleeding emanates from one of the renal papillæ and the mucous membrane covering it, the papillary part of the Malpighian pyramid being engorged and covered with a plexiform mesh of dilated vessels. Other cases had also been reported by foreign observers, in which the characteristic features were that the hæmaturia might disappear spontaneously or after an exploratory operation, that, as a rule, no anatomical lesion could be demonstrated and that medical remedies were unavailing. A theory that the hæmorrhage might be due to an angio neurosis had been put forward—a view supported by its more frequent occurrence in women than in men and by its cure by operation on the kidneys. On the occasion of the patient's second admission to hospital her symptoms were of a still more obscure nature; she had temporary pyuria and pyrexia, but no renal enlargement, pain or tenderness, and she was in a well-nourished condition, all of which helped to make a diagnosis in her case still more difficult and unsatisfactory.—*The Medical Press.*

AN EXCLUSIVE SOUP DIET AND RECTAL IRRIGATIONS IN TYPHOID FEVER.

A. Seibert, in the *Archives of Pediatrics* for Septem-

(*b*) *British Medical Journal*, Feb. 3rd, 1900.

ber, 1900, has been so impressed with the importance of bacteria which have developed in milk as the cause of enteritis in children that he has been asking himself the question as to whether a milk diet in typhoid fever does not add to the intestinal contents an excellent culture medium. More than ten years ago he began feeding his first case of typhoid fever upon a diet other than milk. In the beginning of typhoid fever he empties the bowels with a cathartic and gives nothing but plain cold water for the first twenty-four or forty-eight hours. Then soups are given: meat broths, containing oatmeal, barley, rice and peas, strained and well spiced with salt and pepper. After a few days lentil soup and the yolk of a fresh egg are added to the oatmeal, rice and barley. Five meals in all are given during the day, but at night only fresh cold water. In cases which were not characterized by marked acidity of the stomach contents, hydrochloric acid was given before each meal. Every typhoid case is given from two to four plain water rectal enemata daily. For this purpose rectal tubes are not necessary, as a very slight elevation of the hips will allow of the colon being filled with water, thus thoroughly cleansing the lower bowel. The fountain syringe requires to be elevated about three feet above the patient, and only a short-tipped tube should be employed, which cannot possibly reach any ulceration that may exist in the lower bowel. He has treated 153 cases in this manner, with seven deaths. Three of these were brought to the hospital moribund, and four had complicating bilateral pneumonia.—*Medicine.*

ANÆMIA AND ITS RATIONAL TREATMENT.

By W. E. HOLLAND, M.D., Chicago, Ills.

Consultant, Mary Thompson Hospital, Assistant Gynecologist Illinois Medical College.

From the standpoint of our present knowledge there is no contesting the fact that in all forms of anæmia, iron, alone, or in combination with other recognized remedies, stands without a peer. The results accruing from its use, however, are in direct ratio to the assimilability of the preparation used.

The condition of the digestive organs during the administration of iron, and the consequent lack of power to utilize the remedy as ordinarily prepared, have presented a very discouraging prospect for the patient and disappointment to the physician, who finds that nearly all the chalybeate compounds can be tolerated but a short time—much shorter than is necessary for the accomplishment of the

desired result, producing almost invariably loss of appetite, irritability of the stomach, obstinate constipation, headache, etc.

With an experience of some time in hospital as well as private practice, during which I have been fortunately or unfortunately blessed with an unusual number of complicated and apparently uncomplicated cases of anæmia, I have had the inclination and quite ample opportunity to test the various ferruginous simples and compounds as to their relative merits, and of all used preparations those of the solution of pepto-manganate of iron, for their acceptibility, unirritating properties and relative efficacy, held deservedly undisputed sway and preference, until the preparation "Hemaboloids" was brought to my notice. Skeptical and slow to depart from well-tried though not entirely satisfactory paths, I at last did experiment in a case that had resisted not only my efforts but those of a number of recognized therapeutists, and obtained unsually satisfactory results.

No rritation of the stomach, no anorexia, no constipation, no headache, but, on the contrary, increase of appetite, regularity of the bowels, increase in bodily weight and red blood count.

The following is a record of the most obstinate case treated, which may be regarded as a fair specimen result obtained in upwards of twenty-five cases.

This case was of particular interest since the patient presented an exceedingly unfavorable tubercular history, her mother being affected at the time and two sisters having died of the malady.

Treated with Hemaboloids ℥½ after meals and at bedtime.

1st. week,	weight	157,	Hem.	57	p.c.	R. B. C.	2,900,000	W.B. C.	8,500
2d.	"	"	158,	"	60	p.c.	"	3,100,000	"	8,000
3d.	"	"	160,	"	65	p.c.	"	3,800,000	"	8,000
4th.	"	"	163,	"	73	p.c.	"	4,000,000	"	7,000
5th.	"	"	162,	"	78	p.c.	"	4,300,000	"	6,500

Various preparations have from time to time been lauded for their effect upon the blood and the blood-making organs, and many of the old tried and new remedies have virtues of varying degree, and I have had a reasonable measure of success with all of them, but, from the almost uniformly gratifying results from the use of the remedy just cited, it certainly has in my hands and from my experience been the remedy *par excellence* and well worthy of a trial in all those obstinate forms of blood impoverishment which resist other recognized treatment.

In closing, let me further remark that in the treatment of these cases the necessity and benefit of carefully selected,

concentrated diet, regularity of feeding, fresh air, salt baths and, last but not least, keeping the intestinal tract in an aseptic condition, must not be lost sight of.—*The Medical Times.*

SURGERY.

IN CHARGE OF

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AFTER-TREATMENT OF PERITONEAL SECTION.

Henry T. Byford, *American Gyn. and Obstet Journal*, gives his method of inducing peristaltic action as soon as possible after peritoneal section, for the purpose of preventing intestinal paralysis and adhesions. His success prompted him to use it in simple as well as complicated cases, in order to make the patient more comfortable and to render the convalescence more rapid. This method consists of 4 drams of fluid extract of cascara, or some equivalent, two hours before the time set for operation, dram doses of sulphate of magnesia every hour from the time the patient awakes after the operation, and a high glycerine and water enema (℥ii to ℥iv) every two hours, beginning eight hours after. A high glycerine enema was given before the patient left the table after operations in which adhesions were separated and raw surfaces left. A prompt movement of the bowels and a free passage of flatus not infrequently resulted from this enema before the others were given, and hence he began giving it as a routine practice in order to save, as far as possible, the trouble connected with giving a nauseated patient the salines and later enemas. The treatment must, as a rule, not be discontinued until the patient passes flatus, not only with the enemas, but also freely between enemas, *i. e*, efficient peristaltic action should continue at intervals After the first day means must be taken to maintain frequent peristalsis and a daily evacuation of the bowels. To this end two drams of sulphate of magnesia or two or three ounces of Hunyadi water are given night and morning for two weeks, the dose being regulated according

to the effect. The treatment may be modified somewhat to suit different cases. If a patient be in need of a stimulant, usually an ounce of whiskey is added to the enema administered on the operating table, giving what in the Woman's Hospital is called the one, two, three enema, viz: one ounce of whiskey, two of glycerine and three of water. In patients who have lost much blood, a large, high beef-tea enema is given instead, and repeated every four hours.—*Pacific Med. Jour.*

INJECTIONS OF ETHER IN SEBACEOUS CYSTS.

Emile Sergent, in *La Presse Médicale*, of June 30, 1900 has an interesting article on the treatment of sebaceous cysts by injection. The proceeding was first employed by Vidal in 1883, and was practiced extensively by Lermoyey. Sergent has treated about thirty cases, all of which were radically cured. The manner in which the injection acts has been variously explained. By some it has been thought to be due to an inflammation excited in the wall of the sac, and by others to the power which ether has of dissolving the sebaceous matter contained in these cysts. The writer is of the opinion that the latter explanation is correct, for he says that inflammation is an accidental concomitant due to a failure in aseptic technique. It is possible to treat cysts of all sizes in this way, but those which are small, composed mostly of fibrous tissue with very little sebaceous matter, are not likely to be benefited. The method is inapplicable to cysts that have already undergone inflammatory changes.

Pure sulphuric ether is employed, and the usual operative aseptic procedures are used. A hollow needle connected with a sterilized syringe is thrust directly into the cyst. The cyst is then distended with ether, the needle being allowed to remain in position. The ether immediately dissolves the sebaceous contents of the cyst, and some of it escapes. Then more ether is introduced. The number of injections required will depend upon the size of the cyst and the condition of its walls; commonly from four to twelve are necessary. When the cyst is much softened or fluctuation is apparent, and a brownish crust appears at the margin of the point where the needle is thrust into the sac, the contents may then be readily expressed by opening up the tract with a stylet. If this cannot be done, an additional injection or two may be given. After the contents of the sac have been evacuated, it is possible to remove the sac through a comparatively small opening. It is claimed that this is the best treatment for cysts of medium size. It is not painful, no blood is lost, there

is no danger and no cicatrices are left. The latter the writer regards as of especial importance, as he says there is really little to choose between a head which is covered with wens and one which is covered with scars left by their removal.—*Medicine.*

PROSTATIC HYPERTROPHY.

G. Frank Lydston, in the *International Journal of Surgery* for June, recommends total resection of the spermatic cords as a substitute for both castration and vasectomy in the treatment of prostatic hypertrophy. He gives the following reasons:

It produces less traumatism, a very important item in old men.

There is less danger to the kidney, because of minimized shock.

The testes not being removed, there is none of the psychic disturbance incident to a consciousness of the loss of the testes.

Cocaine may be more safely used.

The subsequent shrinking of the testes is so gradual that little complaint is made.—*The Charlotte Medical Journal.*

MODIFICATION OF WHITEHEAD'S OPERATION FOR HEMORRHOIDS.

The present surgical methods for the treatment of hemorrhoids are reviewed by the writer.

Allingham's modification of the ligature is considered insufficient. The clamp and cautery is unhesitatingly condemned as unscientific and inefficient, and Allingham quoted to show that it causes great pain, hemorrhage is apt to result, sloughing is considerable, and a long time is required for healing. The hypodermic method is severely criticised because it is impossible to confine the action of the agent used, hyperplasia of tissue is likely to follow, and secondary abscesses are not uncommon. Cutting off each tumor and drawing the cut surfaces together by means of continuous sutures is found objectionable because it is not adaptable to cases in which the whole circumference of the anus is involved; there is danger of infection, and other reasons.

The author proceeds as follows: He grasps the hemorrhoid by means of clamp forceps, puts it upon the stretch, and begins with his running sutures at the upper or mucous end of it, cuts small portions of the stump, taking stitches after each incision until the mass is removed. Then the forceps are withdrawn and the stitches made tight. If the entire

anal circumference is involved, the tissues are grasped at Henle's white line and pulled down and out. The incision is made in the median line at the posterior commissure and the sutures begun at the bottom of this incision. He catches the part by means of clamp forceps and proceeds as in the removal of a single hemorrhoid.

Non-exposure to infection and healing by first intention are claimed by the author as special advantages for his method.—*Dr. S. T. Earle, Trans. Amer. Pract. Soc., Post-Graduate.*

THE POST-OPERATIVE TREATMENT OF HEMORRHOIDS.

Dr. J. R. PENNINGTON (*Trans. Amer. Pract. Soc.*) makes the point that the after-treatment of hemorrhoids, as practiced at present, is apt to give rise to much pain to the patient, and is often the true cause of hemorrhage, stricture, ulceration and other dangerous complication.

The pain, he claims, is due to the protrusion and swelling of small tabs of skin after the ligature or cautery, and as the tender granulation-sprouts, which find their way into the meshes of the gauze, are broken off on the removal of the dressing, the bleeding is also apt to be considerable, leaving a field fraught with dangerous possibilities to the surgeon and his ward.

The author proposes to overcome these difficulties by the use of a specially devised tampon, which consists of a rubber tubing around which he wraps some sterilized gauze, and the whole covered with a rubber covering and dusted with an antiseptic powder. Movement of the bowels is induced in 48 hours, and the dressing removed before defecation. Then the parts are cleansed and dusted and the bandage put on.—*Post-Graduate.*

SURGICAL TREATMENT OF NON-MALIGNANT STRICTURES OF THE RECTUM.

The various procedures for the relief of this condition are considered and for the most part condemned.

Dilatation of the stricture by bougies causes an excessive irritation with the formation of new fibrous tissue which increases the stricture in time.

Divulsion, producing an enormous death rate, is justly condemned.

Internal proctotomy is extremely dangerous because a wound is made in a septic field, with no chance of free drainage.

Complete proctotomy provides free drainage, but there is so much extra scar tissue added that the condition of the patient is worse than before the operation.

Resection with end to end anastomosis is no better, as ultimately the stricture will re-form, on account of the irritation caused by the peristaltic action of the gut at the point of union.

The author speaks of two operations, one for stricture above, the other below the levator ani. For the former he recommends laparotomy in the median line, anastomosis between the sigmoid and rectum below the stricture bringing two peritoneal surfaces together, which he scarifies first, then sutures to insure adhesion, provides for drainage, and closes the abdomen. He now clamps the septum from time to time, by inserting the blade of a specially constructed forceps through the anus into the sigmoid and the other along the rectal wall until it is completely severed.

For stricture below the levator ani, he produces a mucous fistula, by passing a heavy silk thread on an aneurismal needle through the anal opening, carrying it through the rectal wall posterior to the stricture and again into the rectum above the constriction, and tying it loosely. The production of the mucous fistula prevents the formation of scar tissue. The thread is left in three months, at which time a second operation is performed and the stricture severed upon a probe.—Dr. Joseph B. Bacon.—(*Trans. Amer. Pract. Soc., Post-Graduate.*

THE DIAGNOSIS AND TREATMENT OF CONGENITAL DISLOCATION OF THE HIP.

The author believes that congenital cases of dislocation of the hip are far from uncommon, and are met with in individuals who are otherwise healthy. It is on account of its reputed rarity that it is apt to be overlooked or mistaken for some other affection of an entirely different kind. To confirm this opinion a number of cases are reported. Some were supposed to have spinal disease and others infantile paralysis. The diagnosis depends upon the attitude of the child while standing, the peculiarity of the gait in walking, the prominent hip or hips, shortening of the limb, if single dislocation, pain, delayed walking, limitations in the motions of the joint, crepitation, movement sometimes of the head of the bone over the pelvis, and above all the relation of the head of the bone to Nélaton's line. The writer's plan for treatment is to use by manual or mechanical means all the

force necessary to bring the head of the bone to its normal site. In this case the proper muscles are elongated, which is safer than cutting the wrong muscles.

The non-cutting reduction method is rarely effective after the age of four or five, but is especially effective in infants or in those under two years of age. No unpleasant symptoms have been traced to the severe traction, and in some cases 150 to 200 pounds were used.—*Dr. W. E Wirt, Cleve. Med. Gaz, Post-Grad.*

SURGICAL HINTS.

Hernias co-existing with adherent omentum are never safe, and especially so in men of active life and habits. In these cases it is always best to advise operation.

In cancer of the breast the presence of a large amount of fat renders less easy a thorough removal of the glands. Hence the prognosis of cure or prolonged survival must be more guarded in fat than in lean women.

In all plastic operations it is important to remove the stitches as soon as possible. If left too long in the skin they will cause the formation of small scars, while if the operation has been done through mucous membranes the cutting through of stitches causes the formation of little tags.

Sickly, pale children with clubbed fingers may have chronic bone disease, or bronchiectasis, or congenital heart trouble, but in the great majority of instances there is an empyema, and hence the necessity of always carefully examining the lungs in this class of children.

When investigating the rectum with a long bougie it is always well to remember that there are two possible sources of error. In the first place the instrument may so double over that a mistaken idea of the length of the channel will arise. On the other hand, the bougie may be arrested by one of Houston's folds, thus simulating a stricture.

It is only permissible to do an incomplete operation for cancer when it is knowingly performed with the object of relieving pain, soothing the imagination by giving the patient a faint hope, and getting rid of a loathsome sore, and because we know that recurrence in a scar is usually much less painful than the original ulcerative process.

In the diagnosis of malignant tumors it is well to recollect that the element of pain is quite an uncertain one. Sarcomata, for instance, are usually less painful than carcinomata, and yet we occasionally encounter cases of painless carcinomata of various regions. In some instances of adenoma the pain may be just as severe in as either of the other two.

In the presence of large aneurisms of important vessels it is well to remember that operation is most likely to succeed when the occurrence is recent, when there is no evidence of aortic or mitral disease, when there is an absence of the rasp sound along the aorta, which would indicate extensive atheroma, and when there is no important visceral disease.—*International Journal of Surgery; American Practitioner.*

MEDICO-LEGAL RELATIONS OF THE X-RAYS.

The following conclusions were unanimously adopted as expressing the views of the American Surgical Association:

1. The routine employment of the X-ray in cases of fracture is not at present of sufficient definite advantage to justify the teaching that it should be used in every case. If the surgeon is in doubt as to his diagnosis, he should make use of this as of every other available means to add to his knowledge of the case, but even then he should not forget the grave possibilities of misinterpretation. There is evidence that in competent hands plates may be made that will fail to reveal the presence of existing fractures or will appear to show a fracture that does not exist.

2. In the regions of the base of the skull, the spine, the pelvis, and the hips, the X-ray results have not as yet been thoroughly satisfactory, although good skiagraphs have been made of lesions in the last three localities. On account of the rarity of such skiagraphs of these parts, special caution should be observed, when they are affected, in basing upon X-ray testimony any important diagnosis or line of treatment.

3. As to questions of deformity, skiagraphs alone, without expert surgical interpretation, are generally useless and frequently misleading. The appearance of deformity may be produced in any normal bone, and existing deformity may be grossly exaggerated.

4. It is not possible to distinguish after recent fractures between cases in which perfectly satisfactory callus has formed and cases which will go on to non-union. Neither can fibrous union be distinguished from union by callus in which lime salts have not yet been deposited. There is abundant evidence to show that the use of the X-ray in these cases should be regarded as merely the adjunct to other surgical methods, and that its testimony is especially fallible.

5. The evidence as to X-ray burns seems to show that in the majority of cases they are easily and certainly preventable. The essential cause is still a matter of dispute. It seems not unlikely, when the strange susceptibilities due to

idiosyncrasy are remembered, that in a small number of cases it may make a given individual especially liable to this form of injury.

6. In the recognition of foreign bodies the skiagraph is of the very greatest value; in their localization it has occasionally failed. The mistakes recorded in the former case should easily have been avoided; in the latter they are becoming less and less frequent, and by the employment of accurate mathematical methods can probably in time be eliminated. In the meanwhile, however, the surgeon who bases an important operation on the localization of a foreign body buried in the tissues should remember the possibility of error that still exists.

7. It has not seemed worth while to attempt a review of the situation from the strictly legal standpoint. It would vary in different States and with different judges to interpret the law. The evidence shows, however, that in many places and under many differing circumstances the skiagraph will undoubtedly be a factor in medico-legal cases.—Philadelphia Meeting, *Pacific Med. Jour.*

CONDITIONS SIMULATING APPENDICITIS AND PERI-APPENDICULAR INFLAMMATION.

Janeway (New York Medical Journal) describes the different lesions which may be mistaken for appendicitis, and mentions neuralgia as one of the troubles. The cases in this category relate to those neuralgais whose origin is obscure and can not be referred to any abnormal condition of any organ. There are neuralgic pains reflected from above, as in pneumonia and pleurisy. Another source of difficulty in diagnosis is afforded by the condition of the right kidney. Among these conditions may be mentioned renal colic, when somewhat protracted, and especially when accompanied with fever. Still greater trouble has been occasioned by hydronephrosis, for in this trouble there is a swelling on the right side, with some tension of the abdominal muscles. Intermittent hydronephrosis, hydronephrosis with a displaced kidney and a movable kidney, may be mistaken for appendicitis. Among the intestinal sources of error in diagnosis are ulcers of a comparatively latent course, gastro-intestinal catarrh with colic. Tubercular ulcers, with tuberculous peritonitis over and about the cecum may give rise to very great difficulty in diagnosis. Fecal impaction may at times simulate peri-appendicular inflammation. There is a class of cases in which there exists an ulcer or narrowing, non-malignant, of the hepatic flexure of the colon, which

may be accompanied from time to time by accumulations of feces in the cecum and colon. These patients have occasional fever also. These combined events may give rise to considerable troublein diagnosis. The pain and tenderness accompanying certain cases of typhoid have led to an operation for appendicitis, as have also the general pains of follicular tonsillitis. As other troubles which may cause errors in diagnosis may be mentioned abscess of the ovary, salpingitis, retained menstrual fluid, retroperitoneal abscess, and at times hypochondriasis.—*The Chicago Clinic Am. Practitioner.*

THE ABORTIVE TREATMENT OF BUBO.

H. M. Christian, in the *Therapeutic Gazette* of August 15, 1900, says that highly satisfactory results have been obtained by the abortive treatment of bubo. Successful application of the method depends upon its being instituted early, before suppuration has set in. Another condition is that it shall be due to gonorrhea, chancroid or herpes, as tubercular infiltration of the gland is not influenced by the treatment. The treatment recommended by the writer consists in the direct application of the following ointment:

℞ Ung. hydrarg.....
Ung. belladonnæ.....
Ichthyol.....
Lanolin.....ää 3 ij.

The ointment is spread upon a piece of surgical lint, and applied directly to the swollen gland. Cotton is next laid over the gland, and the whole is held in its place by a spica bandage, with firm pressure. This treatment is carried out every day until resolution takes place, which is usually accomplished in from ten days to two weeks. Twenty buboes have been treated in this manner, of which twelve were successfully aborted. Eight of the cases followed gonorrhea and four chancroid. Of the eight cases where the abortive treatment failed, six were cases of tubercular adenitis. The result of this treatment has convinced the writer that fully 50 per cent. of buboes other than tubercular can be successfully aborted by this treatment, provided only that it be employed before the formation of pus.

THE TREATMENT OF EMPYEMA.

To summarize the treatment of empyema the following propositions, according to E. Martin (Therapeutic Gazette), seem tenable:

1. Empyema is best prevented by promptly evacuating all considerable inflammatory effusions.

2. In the diagnosis of these effusions, by means of exploratory aspiration, the kin should be punctured by a tenotome at the point where the needle is to be driven in.

3. Serous effusions are best evacuated by aspiration. If they reaccumulate after the third evacuation, they should be subject to continuous siphon drainage, the puncture being made by a small trocar and canula, the latter being of such size that a small drainage-tube may be slipped through it.

4. Recent empyemata are best treated by continuous siphon drainage, the tube being introduced through a canula of at least the diameter of the little finger.

5. When, because of a narrow intercostal space, or because of constant blocking with fibrinous material, siphon drainage thus provided is inadequate, an inch of one of the ribs (usually seventh or eighth) should be resected, and a drainage-tube the diameter of the thumb should be used.

6. When the conditions are such that it is obviously impossible for the lung to expand under the influence of siphon drainage and respiratory exercises, Delorme's operation of stripping the pseudomembrane from the compressed lung should be attempted.

7. When Delorme's operation is impracticable, a resection of the ribs (Estlander) or the chest wall and thickened pleura (Schede), corresponding in extent to the size of the underlying cavity, is indicated.—*Medical Age.*

INJURIES ABOUT THE SHOULDER AT BIRTH.

Some of the conclusions given after a study of obstetrical injuries about the shoulder are:

True congenital dislocation of the shoulder, that is, defective development of the scapula and head of the humerus is of extremely rare occurence.

True traumatic dislocation of the shoulder at birth or in early infancy is of extremely rare occurrence.

Obstetrical paralysis is of Erb's type, due, probably, almost invariably, to a stretching and in some cases a rupture of the two upper roots of the brachical plexus.

Obstetrical paralysis is usually recovered from entirely in the course of a few weeks or a few months. If recovery does not occur within this period the prognosis is very much more serious.

After an infant's arm has been held in the position of inward rotation for some months, the posterior part of the capsule becomes so stretched as to permit the head of the humerus to slip out of the glenoid cavity posteriorly, while the anterior portion of the capsule and the pectoralis major

are shortened. This backward subluxation is always made easier by the relatively small size of the glenoid cavity in infancy.

Any abnormality in the shape of the head of the humerus or in the glenoid in a case accompanied by paralysis or lack of development of the deltoid and supra-and-infra-spinatus muscles is probably secondary to the paralysis, and if accompanied by a dislocation is not to be looked upon as the primary cause of the dislocation. Lack of bony development of a paralyzed arm may become very marked after the lapse of years, and this lack of bony development is not in any way to be regarded as proof of a congenital defect.

All early cases of obstetrical paralysis are to be treated by sling or bandage, which will support the paralyzed muscles and prevent dragging on the ligament and injured nerves.

In cases of obstetrical paralysis which persist without improvement there is reason to hope that surgical intervention looking to a union of the torn ends of the fifth and sixth cervical roots at a point from a quarter to three-quarters of an inch from their emergence from the canal may be of benefit.

The subluxation resulting from the paralysis is to be treated by stretching or section of the contracted muscles and ligaments, by osteotomy, arthrodesis or muscle transfer, according to the conditions present in each case.—*J. S. Stone in Boston Medical and Surgery Journal, Archives of Pediatrics.*

FRACTURE OF THE NECK OF THE FEMUR IN CHILDREN.

Whitman reports (*Annals of Surgery*, February, 1900) 18 cases in children between the ages of two to sixteen. The physical characteristics of this injury are shortening of the limb of one-half to three-quarters of an inch with corresponding elevation of the trochanter and slight outward rotation of the leg. For several weeks or months there may be discomfort on manipulation, but when repair is complete the range of motion is not restricted or slightly limited, and a slight limp is the only symptom. Until recent years this injury was supposed to be confined to adults. In many instances patients are able to walk about within a few days; thus it may be inferred that the separation of the fragments is incomplete, and that the fracture is rather a bending than a displacement. Discomfort or pain during the stage of repair is very often mistaken for hip-disease. Röntgen pictures show depression of the neck as a whole rather than at

the epiphyseal junction. Whitman has also seen 30 cases of coxa vara (which is, practically speaking, fracture of the neck of the femur) in children, but in many instances there may be inherited predisposition to the deformity, or slight depression may result from rachitis. Reports are given of 6 cases, and all but one of these were treated by operation. The first essential is the restriction of abduction, whether of ligamentous or muscular origin, before operating on the bone. A wedge of bone about three-quarters of an inch in breadth is usually removed opposite the trochanter minor ; the leg is held in extreme abduction by means of a plaster-of-Paris bandage, which should also include the foot until union is firm. In case of fracture of the neck of the femur it is sometimes possible to replace the neck to a certain degree by forcing the limb into extreme abduction and fixing it in that attitude by plaster-of-Paris bandage or other appropriate apparatus. During consolidation an ordinary traction splint is applied.—*Philadelphia Medical Journal Archives of Pediatrics.*

ANAL AND SCROTAL ECZEMA.

In an article on anal and scrotal eczema, J. S. Moreman, M. D., writes : In the very nature of things eczema is a most harrassing affection, but, when it attacks the scrotum or the anus or labii in females, the story of horrors would require some Victor Hugo to describe it correctly. One patient who suffered with eczema around the anus and on the scrotum declared that the punishment which in mythological story is meted out for Tantalus is nothing compared with eczema. The cases of pruritus ani and pruritus vulvæ will be found in a great many instances cases of pure eczema of these parts. Most of the classical writers on these subjects have declared this to be true, and in a practice where I have seen a great many of these cases I am forced to say that I have found nearly all cases of pruritus ani and pruritus vulvæ to be due to eczema. These patients will tell us how the attacks of itching come on, and the desire to scratch will be almost beyond the power of any human to withstand. In noitol we have a remedy that will promptly relieve the itching, and bring about a cure of the eczematous process. The remedy is a liquid, and is to be applied to the eczematous surface every two or three hours, according to the severity and the frequency of the attacks of itching. Noitol overcomes, not only the itching, but relieves the associated dermatitis.—*Wisconsin Medical Recorder.*

Therapeutic Notes.

Glycerine in Fever Mixture.

The *Clinica Moderna* recommends the following mixture as beneficial in allaying thirst and fever:

℞ Glycerini puri	ʒviiss
Acidi citrici	ʒss
Aquæ destil., q. s. ad	ʒxxv

M. Sig.: One to two tablespoonfuls at one dose to allay thirst and fever.—*J. A. M. A.*

Convulsions in Children.

℞ Moschi	gr. ii
Chloralis hydratis	gr. ivss
Camphoræ	gr. xv
Yolk of egg	ʒiiss
Aquæ	ʒiii

M. Sig.: As an enema when the child is unable to take treatment by the mouth.—J. Simon: *Med. Rec.*

Hemorrhoids.

The following prescriptions are recommended for the treatment of painful hemorrhoids in the *Agenda Therapeutica* for 1900:

Extract of esculus hippocastanum fluid.	1 ounce
Chloroform	1 drachm.

Morning and evening at meal times, ten to fifteen drops of this mixture is to be taken in a glass of wine or a little sweetened water; or instead:

Fluid ext. of esculus hippocastanum	6 drachms
Fluid extract of hamamelia	2½ drachms
Oil of peppermint	2 drops

Morning and evening at meal times, fifteen drops of this mixture may be taken in wine or sweetened water.—*Therapeutic Gazette.*

An Antiseptic Varnish to Replace Collodion.

The *Journal des Praticiens* attributes the following to Nicaise:

℞ Thymol	22½	grains
Balsam of Tolu	75	grains
Powdered Shellac	900	grains
Alcohol at 90°	750	grains
Ether	1500	grains

M.—*N. Y. Med. Jour.*

Pleurisy.

Act most promptly in pleurisies with serous effusion of recent origin or of long standing, but they are efficient in simple dry pleurisy, and often act favorably in secondary pleurisy. An agreeable salicylic mixture:

℞ Potassii acetatis	℥i-ii
Acidi salicylici	℥ss
Syrupi limoniis	℥ij
Elix. lactopeptine	℥viij

Sig.: One tablespoonful every three hours.

Endocarditis associated with Rheumatic Fever.

℞ Potass. bicarb	gr. xx
Tinct. hyoscyam	m xx
Aq. camphor	℥j
Aq. destil., q. s. ad	℥j—M.

℞ Quinin. sulph	gr. j
Ammon. carb	gr. ij
Potass. bicarb	gr. xx
Tragacanth	gr. iv
Aq. chloroform	℥iv
Aq. destil., q. s. ad	℥j

M. Sig.: To be taken three times a day or oftener.—*Med. Bulletin.*

Jottings.

To Relieve Pain and Keep Burns from Scarring.

After washing the surface of the burn by allowing a solution of 1 drachm of common soda dissolved in a pint of tepid water to run from a sponge over the surface, apply the following prescription :—

℞ Bismuthi subnitratis..... 1 drachm.
Vaselini..... 1 ounce.
Acidi carbolici..... 5 minims.

This added thickly and covered with a light dressing will relieve pain instantly. (*Journal of the American Medical Association.*)

Vertical Headache.

For the flushings and vertical headaches of women, Dr. Bulkley prescribes :—

℞ Diluted nitric acid..... 1 drachm.
Water..... 2 ounces.

M. Sig.: Teaspoonful in a wineglassful of water three times a day. (*Merck's Archives.*)

Olive oil in large doses, twelve to sixteen ounces daily in cases of cholelithiasis, will often remove the stones.

The objectionable excessive perspiration of the feet can be stopped by bathing them with a little formaldehyde in the water.

An ordinary felon, boil or carbuncle may often be aborted by applying to the area sterile gauze soaked in oil of cedar. Before applying, thoroughly scrub and sterilize the skin with hot bichloride solution, 1 to 100. Cedar oil is rapidly absorbed, and I have not yet known it to fail to abort such local inflammation in twenty-four to forty-eight hours. If fluctuation can be elicited, it is wise to make a deep incision before applying the oil.

The Colonial Office has appointed Mrs. Hamilton Williams, M.B., B.S., to be one of the special service medical officers of the Ashanti force. She has distinguished herself greatly as Prideaux Scholar at the London School of Medicine for Women, and as the winner of the County Council research scholarship last year. We believe that Mrs. Williams is the first woman to occupy such a position in the British service.

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Editorial.

MEDICAL DEFENCE UNION.

The St. Francis District Medical Association, at a recent meeting, decided upon the formation of a Medical Defence Union. The idea has been very largely endorsed, and we hope to see before long developed a large organization, which, if properly conducted, can be powerful only for good. At a subsequent meeting of the Society held at Sherbrooke on the 11th inst., the question of Club or Lodge Doctors was discussed. The majority present seemed to think that the members of Lodges ought to be allowed to select their own medical attendant, and that the Lodge pay his bill. In this way, it was asserted, the Lodges would save money. This we do not believe would be the result. On the contrary, such a plan would soon bring about financial ruin. Lodge practice is at best most unsatisfactory work, and the doctor is the "slavey" of the members, but, so far as we can see at present, it will stay. The only thing, then, to be done is to make terms not derogatory to the members of a learned profession, and which will at all events elevate matters. These might be enumerated as follows:—Treble the amount now paid as a yearly fee; pay one dollar for examination of candidates. Let the physician chosen keep his appointment during good behaviour. The semi-annual election of the Lodge surgeon is useful only as a fitting opportunity for

some member with a grievance to surround himself with a few friends and try to turn the Doctor out. Most likely the grievance has simply been compelling the member to go to his work, when he desired to remain on the Lodge. If members belong to several lodges—the sick benefits of which aggregate more than the member's weekly pay—then each lodge should contribute their proportionate share, so that the member shall draw no more sick benefit than he would wages if at work. This is a serious and a very live grievance. It is a curious commentary on human nature that the working man—who joins combines, strikes for higher wages and double wages if called upon to work after hours—grinds the doctor to work at starvation wages, simply because they have failed to learn that "union" is strength.

NO HOSPITAL CHAPLAIN.

A recent number of the *Dublin Medical Press* says:—"According to the terms of a recent bequest to the Geneva New York City Hospital, the hospital 'shall not have an officer known as a chaplain, or have any person in its service at any time, any part of whose duties it shall be to perform such services as are usually performed by a chaplain.' If the request is not complied with, the money, 50,000 dollars in amount, is to go to another hospital. This peculiar stipulation recalls the condition laid down by Mr. Girard, the founder of the well-known institution in Philadelphia which bears his name. This testator was also animated by a dislike for ministers of religion, who are formally excluded from entering the buildings. A funny story is related in this connection. A gentleman wearing a white tie sought admission, but was informed of the fact that the founder had forbidden clergymen access to the grounds. 'The devil he did,' interjected the would-be visitor. 'I beg your pardon,' said the janitor, 'I see I have made a mistake. Pass in.'"

Among the new medical depots recently established in Montreal is that of the Van Ness-Cooper Company of New York, whose place of business is at 28 St. Antoine Street, and whose telephone number is Main 1420. They manu-

facture a number of preparations that are highly spoken of by our exchanges and also by many leading men of the profession. Among these is Lacto-Lithiated Strontium Compound Van Ness formula), which is specially prepared for use in Bright's disease, where its success has in some hopeless cases said to have been phenomenal. Another preparation made by them is Van Ness Lacto-Marrow Compound; a scientific food compound of pre-digested beef marrow (long bones), eggs, cream, farinaceous matter with hyposulphites and saccharine, held together in solution with choice ferments, making a rich, delicious and palatable food.

The *Dublin Medical Press* says:—"Mr. Lennox Browne was, we believe, one of the first to call attention to the etiological, semeiological and therapeutic analogy which exists between tonsillar inflammations and articular rheumatism, or as he put it, the arthritic diathesis. Without attempting to explain the relationship which presumably exists between the two conditions, its existence is interesting to note. We find almost invariably that persons who are liable to attacks of follicular tonsillitis, for example, have a strong personal or family history of rheumatism; and, on the other hand, those who are free from this taint rarely suffer from this class of angina. The hypothesis of the bacillary origin of rheumatism is rapidly gaining ground, and, influenced by this view, some observers have suggested that the point of entry of the materies morbi is *via* the tonsils. Until the pathology of rheumatism has been more fully worked out, we cannot hope to establish its relationship with tonsillitis, but the subject is one which deserves careful consideration in view of the therapeutical advantages which the solution of the problem may be expected to yield."

Book Reviews.

Lea's Series of Pocket Text-Books. Eye, Ear, Nose and Throat A Manual for Students and Practitioners. By William Lincoln Ballenger, M.D., Assistant Professor of Otology, Rhinology and Laryngology in the College of Medicine of the University of Illinois (College of Physicians and Surgeons); Professor of Otology, Rhinology and Laryngology in the Chicago Eye, Ear, Nose and Throat (post-graduate) College; Member of the International Congress of Otologists (London); Member of the American Otological and Laryngological Association; Fellow of the Chicago Academy of Medicine; Attending Otologist, Rhinologist and Laryngologist at the West Side Free Dispensary, etc., and A. G. Wippern, M.D., Professor of Ophthalmology and Otology, Chicago Eye, Ear and Throat College. Series edited by Bern B. Gallaudet, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons, Columbia University, New York; Visiting Surgeon, Bellevue Hospital, New York. Illustrated with one hundred and fifty engravings and six colored plates. Lea Brothers & Co., Philadelphia and New York.

This little volume, which is one of "Lea's Series of Pocket Text-Books," promises to be of deep interest to those who purpose reading up the subject with which it deals. It is intended for the use of students and practitioners, and will be found excellently well suited to the needs of both. Nearly all the affections of the Eye, Ear, Nose and Throat are more or less briefly described in this volume, the more common being treated with a fullness commensurate with their importance. The illustrations are excellent, and the work is systematically and concisely arranged. We take pleasure in commending the work as invaluable as an aid to students.

R. C.

Hygiene and Sanitation. By Seneca Egbert, M.A., M.D., Philadelphia. Publishers, Lea Brothers & Co., Phil. and N.Y.

A really practical hand-book on Hygiene. It is concise and to the point. It is a new departure in the treatment of the subject, inasmuch as it is made very interesting reading.

The student particularly will cherish this little volume, as it presents the subject in that delectable manner which always seduces him. To the practitioner much well-exhibited new information upon the subject will make this book valuable.

The second chapter on Bacteriology, with reference to public health, will appeal specially to the hygienist, as some morphological theories are treated in a very original manner. In every respect it is a book much to be commended.

A. J. R.

Practical Uranalysis and Urinary Diagnosis. A Manual for the Use of Physicians, Surgeons and Students. By Charles W. Purdy, LL.D., M.D., Queens University, Fellow of the Royal College of Physicians and Surgeons, Kingston, Canada; Professor of Clinical Medicine at the Chicago Post-Graduate Medical School. Author of "Bright's Disease and Allied Affections of the Kidneys"; also of "Diabetes, Its Causes, Symptoms and Treatment." Fifth revised and enlarged edition. With numerous illustrations, including photo-engravings, colored plates and tables for estimating total solids from Specific Gravity, Chlorides, Phosphates, Sulphates, Albumin, Reaction of Proteids, Sugar, etc., etc., in Urine. 6x9 inches. Pages xvi.—406. Extra cloth, $3.co net. F. A. Davis Company, Publishers, 1914–16 Cherry St., Philadelphia.

This work presents the subject of urine analysis in a very attractive style. Dr. Purdy has done much to popularize the estimation of the chief constituents of normal and pathological urine by the centrifugal method.

Several carefully worked out tables are given, showing the relation between the volumetric and gravimetric percentages of albumin, chlorides, phosphates and sulphates in the urine. It is to be regretted that no mention is made of Harvey Cook's method of estimating uric acid quantitatively by the centrifuge. This method promises excellent results, and has the advantage of being rapid and approximately accurate. It is based chemically on the method of Haycroft, in that the uric acid is precipitated as urate of silver and its bulk percentage estimated.

The diseases of the urinary organs and urinary disorders are dealt with in detail. The work will be found satisfactory as a manual for students and practitioners.

A. B.

Clinical Examination of the Urine and Urinary Diagnosis. A clinical guide for the use of practitioners and students of Medicine and Surgery. By J. Bergen Ogden, M. D., Instructor in Chemistry, Harvard University Medical School; Assistant in Clinical Pathology, Boston City Hospital; Medical Chemist to the Carney Hospital; Visiting Chemist to the Long Island Hospital, Boston. Illustrated. Publishers: W. B. Saunders & Co., Philadelphia. Canadian Agents: J. A. Carveth & Co., Toronto, Ont. Price, $3.oo net.

This is a valuable work on urinary analysis and urinary diagnosis. Its subject matter naturally falls into two parts.

In the first part, the chemistry of urine in health and disease is fully considered, and much space is devoted to the microscopical study of urinary sediments. The author gives a detailed account of most of the methods employed in urinary chemistry, but makes no mention of the estimation of total nitrogen in urine by Kjeldahl's method, of which every research-worker in a clinical laboratory is expected to have knowledge. Nor does he allude to the use of

Obermeyer's reagent in the determination of urine in disease or to the estimation of the total acidity of urine. Those and other methods which have been omitted will, it is hoped, be mentioned in a future edition. In the second part, special attention has been paid to the diagnosis of diseases of the kidneys and urinary passages.

We can recommend the work as a clinical guide to urinary diagnosis. It is well illustrated and carefully printed.

A. B.

Rhinology, Laryngology and Otology, and their Significance in General Medicine, by E. P. Friedrich, M. D., translated by H. B. Curtis, M.D. Published by W. B. Saunders & Co., Philadelphia and London. Canadian Agents: J. A. Carveth & Co., Toronto.

This work is designed to show the co-relation and inter-dependence between diseases of the entire organism and diseases of the nose, pharynx, larynx and ears. The author claims that a specialty should not be a thing apart, but that it should take active interest in all the problems with the solution of which general medicine is concerned. Hence, active co-operation between general medicine and every one of the various specialties is regarded as indispensable. The author does not claim originality in taking this standpoint, for other works in this line are extant, but he undertakes in this new work to lay before the profession the development of new points, which abundance of material more recently utilized has justified him in giving what he thinks more exact and well-established information. The special detailed symptomatology of the ordinary text-book is omitted, and the author's desire is to awaken the interest of both general practitioner and specialist in certain matters which require special attention and further elaboration.

The writer of this note can appreciate the author's aim, for he has at this moment a case on hand where the scientific elucidation of the throat symptoms have remained an unsolved problem to the best general practitioners, as well as specialists, which this and the adjoining country possess. The book is distinctly commendable.

G. T. R.

Modern Medicine. By Julius Solinger, M.D., Demonstrator of Clinical Medicine, Jefferson Medical College; Chief of the Medical Clinic, Jefferson Medical College Hospital; Attending Physician to the Philadelphia Hospital, and Frederick J. Kalteyer, M.D., Assistant Demonstrator of Clinical Medicine, Jefferson Medical College; Hæmatologist to the Jefferson Medical College Hospital; Pathologist to the Lying-in Charity Hospital, Philadelphia; Assistant Pathologist to the Philadelphia Hospital. Illustrated. W. B. Saunders & Co., Philadelphia and London, 1900. Canadian agents: J. A. Carveth & Co., Toronto. Price, cloth, $4.00, nett.

No man is to-day able to practice Medicine without having a reasonable knowledge of the various specialties of which his art

consists. Principal among these are physical diagnosis, bacteriology, the examination of the gastric contents, the urine, blood and feces. As this has necessitated the student procuring separate books upon these topics, the authors of this work have combined in one volume, as far as possible, the essential of these branches as applied to Clinical Medicine. The arrangement of the special topics has been adopted to prevent repetition, to present as concise a description of allied subjects as possible, and to link more closely the various divisions. Thus the pathogenic germ of a spinal disease is considered under the head of Clinical Bacteriology, rendering it unnecessary for one already acquainted with such facts to again read the morphology, the biology, the pathogenesis, etc., when dealing with the description of the disease. If the reader should be unfamiliar with the subject, such facts will be found in the section that deals with the micro-organisms that are of importance in Clinical Medicine. A similar course has been followed in regard to physicial diagnosis, examination of sputum, stomach contents, blood, urine and feces. The authors have been most successful in giving the main facts of the etiology, pathology, symptoms and prognosis, but we confess we do not admire the terse and brief outline of treatment which is sometimes given. As illustration we mention Pertussis, where the treatment is summed up in eight lines, and in which we do not find any mention of such drugs as quinine, belladonna, etc., which some physicians from clinical experience consider most valuable. Notwithstanding this fault, the work is thoroughly up to date, and will often be found a valuable counsellor.

F. W. C.

The American Illustrated Medical Dictionary.—A new and complete Dictionary of the terms used in Medicine Surgery, Dentistry, Pharmacy, Chemistry and the kindred branches with their pronunciation, derivation and definition, including much collateral information of an encyclopedic character. By W. A. Newman Dorland, A.M., M.D., Assistant Obstetrician to the University of Pennsylvania Hospital; Fellow of the American Academy of Medicine, together with new and elaborate tables of arteries, muscles, nerves, veins, etc., of Bacilli, Bacteria, Diplococci, Micrococci, Streptococci, Ptomains and Leucomains, Weight and Measures, Eponymic tables of Diseases, Operations, Signs and Symptoms, Stains, Tests, Method of Treatment, etc., with numerous illustrations and 24 coloured plates. Philadelphia and London. W. B. Saunders & Co., 1900. Canadian Agents: J. A. Carveth & Co., Toronto. Price $4.50 plain and $5.00 indexed.

This is one of those Dictionaries that ought to be found on the book-shelf of every medical man, for what you can't find in it is hardly worth looking for. It is absolutely up to date; although it is not an encyclopedia, it is a concise and convenient word book, aiming to furnish full definitions of the terms of Medicine and kindred branches, as well as such collateral information as medical men generally would be likely to look for. Special attention

has been given to the wording of definitions, with the intention of making them clear, concise, yet sufficiently complete. It also contains a large amount of information arranged in tabular form which is not considered ordinary dictionary matter. The very important features of pronunciation and derivation have received the most careful attention. The system used for expressing the sound is extremely simple, and yet it indicates with accuracy the exact pronunciation of the word. The illustrations are exceedingly good, and the coloured plates a very valuable addition to the work. The volume is bound in a flexible cover, which is a very great comfort in its use. The publishers have succeeded in producing a book of very attractive appearance and convenient size. By the use of a large page, with a compact but clear type, they have succeeded in furnishing a volume which has within its cover an almost incredible amount of matter

F. W. C.

The Australian Medical Directory and Hand-Book.—L. Bunk, Medical Bookseller, 15 Castlereagh St., Sydney.

We have to thank the publishers for a copy of this volume, which, besides containing the names of the registered practitioners of the Commonwealth of Australia, is filled with a large amount of useful medical information. It gives the legal medical table of fees of the various provinces, a glance at which would certainly stir up a spirit of envy among Canadian practitioners. The medical laws of the different provinces are given in full, and full particulars of the various Universities are also inserted.

PUBLISHERS DEPARTMENT.

THE LIVING AGE.

Boston's long established weekly magazine, *The Living Age*, opens its two hundred and twenty-eighth volume with the number which bears date on the first Saturday of January. So long a period of continuous publication, running back fifty-seven years, presupposes qualities of enduring value in the magazine and a large measure of attachment on the part of its readers. The fact is that the editors of the magazine have been singularly successful in retaining the characteristics which gave the periodical its original hold upon the reading public, and at the same time broadening its scope and introducing new elements of variety and timeliness All the conditions of periodical publication have greatly changed since Mr. Littell established this magazine in 1844, but, while other magazines have come and gone, the old *Living Age* has held its place and is even more indispensable to-day to alert and cultivated readers than it was half a century ago. It is still the only weekly magazine in its field, and its frequency of issue enables it to reproduce the most important articles from foreign, and especially from British magazines, reviews and literary weeklies, with a freshness impossible under other conditions. Literature, art, science, biography, travel, poetry, public affairs and the best fiction in short and serial stories find a place in its well-stored pages, and there is not a single weekly number which does not contain something which intelligent readers of whatever special tastes would be poorer for missing. The magazine is published by the Living Age Company, Boston.