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# THE CANADA MEDICAL RECORD.

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## CONTENTS.

### ORIGINAL COMMUNICATIONS.

Medical Practice in British Guiana,  
by J. Eneas, C.M., M.D. .... 121

### PROGRESS OF MEDICAL SCIENCE

Recent advances in the Therapeutics of Diseases of the Skin, 125.  
—The Treatment of the Night-Sweating of Phthisis, 130.—  
The Treatment of Acute Rheu-

matism, 133.—Treatment of Secondary Puerperal Metrorrhagia, 134.—Management of the Shoulders in Labor, 136.—Epistaxis in Children, 138.—Angels' Whispers, 138.—Cough and its Local Treatment, 139.—Aspiration of the Gall Bladder, 139.—The Treatment of Abortions, 140.—Obstetric Aphorisms, 141.—Ovarian Irritation and Pain, associated with Cervical inflammation, 142.—Iodoform in Uterine

and Catarrhal Diseases, 142.—  
Chronic Eczema of the Palm.... 142

### EDITORIAL.

Correction, 143.—College of Physicians and Surgeons of the Province of Quebec, 143.—The late Dr. Kenneth Reid, 143.—Tonga, 143.—W. R. Warner & Co.'s Preparations, 144.—Personal..... 144

## *Original Communications.*

### MEDICAL PRACTICE IN BRITISH GUIANA.

By

J. ENEAS, C.M., M.D., District Medical Officer, Wakenam, Demerara.

In the Colony of British Guiana there are about forty Medical practitioners; of these twenty-six are Medical Officers in the Immigration Department, a chief Medical Officer, twenty-two permanently appointed to rural districts, and three supernumeraries who may be called upon to fill vacancies that may occur in the districts from sickness, death or other causes, but, when not employed in the districts, they are attending the Colonial Hospital; there are, however, generally three or four district Medical Officers away on leave all through the year; there are nine Medical Officers in the Colonial Hospital, Lunatic Asylum, Alms House, Penal Settlement and as Port Officer, the others are private practitioners in Georgetown, the metropolis of the Colony. All Medical Officers except the resident surgeons in the Colonial Hospitals and Lunatic Asylum are allowed to attend to private practice, but which, however, is not of much importance in many of the rural districts. The salaries in the rural districts range from £500 to £1000, but the expense of living is very high, consequently one does not save as

much as may be imagined out of these amounts, particularly in the districts to which the smaller salaries are attached, as generally in the latter there is the least private practice. There is, however, this advantage in connection with the public service in that Colony, one can retire after ten years service if at the age of fifty-five, or if from bodily illness he is unable to continue more than ten years in the service of the Colony, the retiring allowance being one-fiftieth of the salary received for every year that one has been in the service up to the thirty-five years. It is, however, very rare that any one reaches that number of years. One Medical Officer retired three years ago after a service of thirty-three years, and with a retiring allowance of over three thousand dollars per annum. The Medical Officer is allowed a reasonable leave of absence every six years, and oftener if his health requires it. Again, it being compulsory to pay into the Widows' and Orphans' Fund at the rate of four per cent. of the salary, one's widow and children are sure of a fair pension at his death, even if he should die within the first year of his entry into the service. His retiring from the service after ten or more years will not affect his widow's pension, providing four per cent. of the retiring allowance, which is optional, is regularly paid in.

These appointments are generally made by the Secretary of State for the Colonies direct, but in some instances the Governor appoints and then

recommends the party to the Secretary, who almost invariably confirms the appointment. If possible, however, it is far better to get a direct appointment, which in the case of Medical Officers on the Immigration staff is always a supernumerary office at a salary of three hundred pounds. Changes are so frequently occurring that an appointment to a district soon follows.

The duty of the district Medical Officer is to attend to all Estate Hospitals at stated intervals, or oftener if necessary, and the police and recognized paupers in the district when required. He is also to attend all Criminal Courts when subpoenaed without compensation except his travelling expenses. He has to make all post mortem examinations when ordered by a coroner, but for that he receives a fee of ten dollars. He also receives a fee of five dollars for giving evidence at the coroner's inquest.

The number of Estate Hospitals in the several districts vary from one to eight, and in some districts they are several miles apart, consequently a large portion of his time is spent in going to and from the hospitals, which adds very materially to his expenses in the way of horseflesh and waggons. These hospitals are certified to accommodate from thirty to eighty patients each, but generally there are not more than half that number in them; occasionally, however, they are full, and sometimes even have more than the certified number.

The patients are chiefly Coolies, or East Indians, laborers on the estates, numbering from two hundred to two thousand on each estate or plantation, indentured and free. The former are entitled to all the privileges of the hospitals, according to the immigration ordinance, and the latter only when they get an order from the manager or other estate official, and this is invariably given when asked for while working on the plantation. The names of the patients are entered on the daily case book by the head sick nurse before or on the arrival of the Medical Officer, and he then makes them in or out patients as he thinks best, except in the case of those who have not been a year in the Colony, when it is specially requested that they be made in-door patients.

In the year 1880 there were treated in the Estate Hospitals throughout the Colony, (in all about one hundred,) 105,552 patients, of whom 1480 or 1.4 per cent. died. Of these patients 73,744 were indentured East Indians or Coolies, that is those who had not been in the Colony five years. Of

the remainder, all of whom were free laborers, there were 24,761 East Indians, 1023 Chinese, 4018 Creoles, 992 Barbadians, 734 Portuguese, 162 Africans, 49 Europeans and 63 other nationalities. Of the whole number 70,410 were treated as in-door patients, of whom 1407 or 20.05 per thousand died, and 35,142 as out-door patients, of whom 73 or 2.09 per thousand died. 181 cases were admitted into the hospitals in a moribund condition, and died on the day of admission, and of these 71 were children. Of the 70,410 patients treated in-doors, 53,745 were adults with 486 or .815 per cent. deaths, and 2454 children under ten years with 65 or 2.63 per cent. deaths. In all 56,199 indentured, with 551 or 98 per cent. deaths, and 14,211 free laborers, with 856 or 6 per cent. deaths. The great difference between the number of deaths in the indentured and free laborers shows the advantage of the supervision by the estates officials over the former class. On the first sign of illness they are ordered to the hospitals, and are compelled to go, whereas the latter class only go to the hospitals whenever they feel inclined, as they are not compelled. Of the whole number treated as in and out-door patients, the rate of deaths in the several nationalities were: of East Indians, 1.27 p.c.; Chinese, 4.1 p.c.; Creoles, 2.7 p.c.; Barbadians, 2.9 p.c.; Portuguese, 2.4 p.c.; Africa, 9.2 p.c.; Europeans, 6.1 p.c.; other nationalities, 11.01 p.c.

The larger portion of those admitted in a moribund condition were free laborers. The number of those who died within the first year of their residence in the colony, or period of acclimation, were 173, or 11 per cent. of all the deaths, and of this number 21 were children; of these deaths 59 died within three months, 56 within six months, 38 within nine months and 20 within twelve months. After deducting the number of deaths within the first year from the whole number of deaths among the indentured immigrants treated in-doors, we find that only .68 per cent. died between the first and fifth year of their indenture.

There were in 1880 22,718 indentured Coolies, of whom 173 or .72 per cent. died within the first year and 383 or 1.7 per cent. between the first and fifth year of their indenture; in the same year there were 45,523 free Coolies, of whom 701 or 1.54 per cent. died.

Of the prevailing diseases, the more important are intermittent and remittent fever, simple bilious and occasionally of a pernicious or congestive type, diarrhoea and dysentery, debility, dropsy and

anæmia, bronchitis, pneumonia and phthisis, ulcers and cutaneous diseases generally. Of the 70,410 treated as in-door patients in the year 1880, there were 31,449 cases of intermittent fever with 150 deaths, 985 cases of remittent fever with 59 deaths, 3334 cases diarrhoea with 249 deaths, 3501 cases of dysentery with 146 deaths, 2599 cases of debility, dropsy and anæmia with 195 deaths, 2108 cases of bronchitis with 188 deaths, 411 cases of pneumonia with 106 deaths, 227 cases of phthisis with 84 deaths, 370 cases of convulsions with 118 deaths, 1333 cases of rheumatism, 1059 cases syphilis, 5749 cases of ulcers, simple and sloughing, 2504 wounds and 933 other injuries with 22 deaths; 3541 cutaneous diseases, 748 cases of diseases of eye and ear, 602 cases gonorrhœa, 2009 cases of diseases of stomach, liver and spleen, and other diseases of less importance.

The large number of ulcer cases arise from the dirty habits of the Coolies. They often get a large number of chigoes, a little insect very like a flea, and which burrows under the skin, into their toes and other parts of the feet, and which remain there until cysts or bags of eggs are formed around them, and when taken out leave large cavities, but if not taken out, which is a common occurrence, they decompose, and very often cause sloughing ulcers, and which frequently end in an amputation of the toes, and sometimes the whole foot. Capital operations are very rare; notwithstanding the large amount of machinery used on the estates, the various injuries and wounds received are not generally very serious.

In the treatment of intermittent and remittent fevers quinine is used very freely, and is generally considered a certain specific; other preparations of the cinchona, however, are used successfully. A combination of the alkaloids prepared in India from red cinchona bark grown there, and known as cinchona febrifuge, has been recently introduced by the Government and used by all the Medical officers, who were requested to report on it effects. The reports have generally been in favor of this preparation. It is the same as that known in the United States as Quinetum, and very probably that of Quinquina. We have used the compound tincture of cinchona of the U. S. Pharmacopœia with bromide of potassium with much advantage. The tincture of iodine has also been used very successfully, especially in those cases of intermittent fever complicated with enlarged spleen. The latter is often seen so large as to

extend across the umbilicus. Tincture of iodine is used in doses of 10 and 12 drops three times a day; tincture of iron, gentian or cinchona may be added, in some cases, with advantage:

In the treatment of dysentery large doses of ipecacuanha is generally prescribed, but some prefer small doses, from 3 to 5 grains, with more or less of Dover's powder and about the same quantity of gallic acid; of course, this is only used after the bowels have been relieved with castor oil or other mild laxatives.

Iodoform is successfully used in indolent ulcers and indurated syphilitic ulcers or chancres.

The Coolie as a rule is a very weak subject, seldom eating anything but rice and currie in their homes, and consequently has to be freely stimulated while under treatment from diseases of a depressing nature. Only a certain number of Coolie women are brought to the Colony. The morals of both Africans and Coolies are of the lowest character, consequently syphilis is a common disease among them. At the Government Hospital for Lepers it was found necessary to erect a new building at some distance from the old one so as to separate the male from the female, as it was impossible otherwise to keep them apart. At the time of the separation the doctor was violently attacked by the women, and would have lost his life but for opportune assistance. They blamed him for the separation. Even under such circumstances, and although suffering from leprosy, children have been born in the establishment. The skin disease known as Yaws is common. Very few confinements are attended by Medical officers, and then only in hospital. The Coolie woman assumes a sitting posture at delivery, afterwards they are rubbed all over with oil; no bandage is used; in two or three days they are about as usual. The navel cord of the infant is cut and left uncovered until it falls off. Among the native Indian population the women attend to their usual duties immediately after delivery, and the husband does the lying-in; he goes to his hammock and plays sick for over a week. Snake bites are not common. There is a species of fish called the hooktail which very often causes serious wounds on the legs of bathers as it cannot be seen in the muddy sea water.

In regard to the qualifications required to obtain appointments in this Colony a brief explanation is necessary.

For some years past there have been considerable objections made against Colonial graduates

holding positions as Medical officers in Her Majesty's Army and Navy and in the Mercantile Marine ships carrying passengers up to a certain number, when they would come under the control of the British Board of Trade. Only a few years ago there was some trouble in the Allan Line of Steamships because they carried Canadian graduates as Medical officers. The case, however, was immediately represented to the proper authorities, and was satisfactorily arranged. The Medical Council of Great Britain then took up the subject of recognizing the Colonial Universities, and through their representations a new Medical Bill was laid before the British Parliament, and discussed at considerable length. The Bill, however, did not pass through Parliament in consequence of some disagreement about certain sections of it concerning the Medical Council and its jurisdiction, &c., and not on account of the recognition of Colonial Universities. Several other bills have been since laid before Parliament and met a similar fate.

The subject of recognition of Colonial graduates was freely discussed at the several meetings of the Medical Council, and it was proposed that they be recognized and allowed to register their names in the British Medical Register, but in a separate column to show that they were practicing in the Colonies. Some members of the Council, however, were of opinion that Colonial graduates should be registered in the same column, and that they be accorded equal privileges with graduates of British Schools of Medicine, as they considered that Colonial graduates were fully worthy of the privilege of being placed on the same footing as themselves, plainly showing their opinions of, and feelings towards, the Colonial Medical Schools. It was not lost sight of, however, that the Ontario Medical Council refused to recognize British graduates, even though they were registered in the British Medical Register, and would not allow them to practice medicine in that province until they had passed a satisfactory examination before a Medical Board. The opposition on the part of the Ontario Medical Council was also freely discussed in the British Medical Journals, and caused many persons to oppose the recognition of Colonial graduates generally. This opposition being at variance with a section of the Medical Act of Great Britain passed in 1858, in which it is distinctly stated that any person registered in the British Medical Register can practice Medicine in any

part of Her Majesty's Dominion, but that he must first pay the licensing fee, if a license is required, by order of the local authorities. This was shown in an appeal case by one of the Judges of Ontario three or four years ago. A Scotch graduate applied for a licence to practice, but it was refused until he had passed an examination before the Medical Board. He declined to be examined, and began to practice near Toronto, when he was summoned before one of the lower Courts and fined. He appealed to a higher Court, and the decision of the lower Court was set aside under the section of British Medical Act named above. All persons practicing Medicine or Surgery in Great Britain and the Colonies prior to the passing of the Medical Act of 1858 were privileged to register their names in the British Medical Register, and many practitioners in the Colonies took advantage of this privilege.

As a rule, the majority of Medical practitioners in all Her Majesty's Colonies except the Dominion of Canada are graduates or licentiates of England, Scotland or Ireland; many of them, however, are not registered as they have never practiced medicine there, but have immediately gone to the Colonies, where the degrees are recognized on examination by the local authorities, and permission is at once granted them to practice. These gentlemen are with few exceptions prejudiced against Colonial graduates, and of course will, whenever an opportunity offers, try to poison the minds of the public as well as the authorities against them. The British Government, and its representatives in the Colonies, now begin to see the value of Colonial degrees, knowing that the curriculum of studies in the Colonial Medical Schools is quite as good as the majority of those in Great Britain, and that a number of Colonial graduates are now holding official appointments in many of the Colonies; still it is very perceptible that the preference is given to graduates of Great Britain and Ireland. It is therefore advisable that Canadian graduates, who may be disposed to practice medicine in any of Her Majesty's Colonies except Canada, go to Great Britain and pass an examination for a degree from one of the Licencing bodies there, and register their names in the British Medical Register, that they be the better able to fight against the prejudice above named.

Canadian Schools of Medicine are well represented in the Colony of British Guiana, there being one graduate from Toronto University and two

from Bishops College. The gentleman from Toronto, however, is a licentiate of the Edinburgh College of Surgeons. Two of these gentlemen are District Medical Officers in the Immigration Department, and the other is Assistant Resident Surgeon in the Colonial General Hospital.

## *Progress of Medical Science.*

### RECENT ADVANCES IN THE THERAPEUTICS OF DISEASES OF THE SKIN.\*

By W. ALLAN JAMIESON, M.D., F.R.C.P., ED.

I have thought it would not be uninteresting, possibly also not uninteresting, were I to summarize some of the more recent advances and improvements in the mode of treatment of skin diseases which have stood the test of practical experience, as an introduction to a course of lectures on diseases of the skin.

It has frequently struck me when reading over works on therapeutics, how small a space comparatively is in general devoted to the actions and uses of drugs when applied to the surface of the body, as compared with that set aside to the supposed influences they exert when swallowed or otherwise brought into contact with the mucous surfaces of its interior. I say supposed, because, though the mode in which some few substances so introduced act on the economy has been pretty satisfactorily worked out, there are still a vast number concerning the *modus operandi* of which we know very little indeed, some nothing at all. True, while certain remedies are taken under certain diseased conditions, certain results may with tolerable accuracy be predicated to follow, but in which way this is effected theory even does not in all cases explain. In the case of internal medicinal agents, the difficulty of unravelling this action is great, and all the more so, because in this country, through the influence of a misguided sentimentalism, experiments on the lower animals are practically prohibited; but the same difficulty should not be experienced to anything like the same extent in the case of external remedies. Take sulphur, for instance, when swallowed in a sufficient dose it acts as a purgative. In smaller and continuous doses it seems to increase the amount of water excreted by the skin, is a so-called diaphoretic, at all events it appears in the sweat, probably as sulphuretted hydrogen, for under such circumstance it blackens silver coins and ornaments. But what is its action when applied as a paste or ointment to the surface of the body? The answer to such a question would be

in the majority of cases, "it cures scabies and is good for acne." In the first case, probably the heat of the body oxidizes some of the sulphur, and as sulphurous acid it acts destructively on animal life; in the second, a different explanation must be given. Sulphur when applied to the surface of the body acts as an irritant and stimulates the cells of the rete Malpighi to a more rapid growth. Hence, when indirectly used, an increase of the normal desquamation of the cuticle and of that of the endothelial cells of the glands of the skin takes place. In acne this normal exfoliation is always sluggishly performed, and thus the stimulant action of the sulphur leads in time to a healthier condition. We may even go a step further, and maintain that so applied, sulphur rouses the muscular element of the skin to more active contractility, and thus diminishes the passive hyperemia of acne rosacea. One of the most active of the sulphur compounds, the sulphide of calcium, has been much praised by Ringer, in what may be called the furuncular diathesis, as hastening the maturation of those boils which have already appeared, and lessening the tendency to the formation of fresh ones. Bulkley has particularly insisted on its value in hordeolum or sty, several of which are so apt to form on the eyelids in succession. Sulphide of calcium is a very unstable salt, and it may well be that the sulphur set free from the calcium may in its nascent condition exert a special influence on the peri-glandular plexuses, and on the migration, fatty degeneration and death, of the exuded leucocytes. This, however, is but a theory; and while I believe that no one can satisfactorily use a remedy without a theory as to its mode of action, still this is not the place for airing hypotheses, but for placing before you ascertained facts.

In the treatment of skin diseases we rely much on ointments, as these have certain valuable properties not possessed by lotions or liquid applications in general. In conditions of chronic inflammation of the skin, the long-continued congestion leads to thickening and induration, which prevents the sebaceous and sudoriparous glands from performing their proper functions, so that the surface is not lubricated, and becomes dry, hard, and brittle. The oily material must be artificially replaced. Now in doing this the great difficulty has been that animal fats, of which prepared lard was the usual representative, and also most vegetable ones, soon became rancid, all the more rapidly when combined with metallic oxides or salts, and at the heat of the body. The fatty acids so engendered irritated and excoriated the skin, and the ointments often did more harm than good. At first, attempts were made to prevent the lard from becoming rancid by adding preservative ingredients, as benzoic acid, in Mr. Erasmus Wilson's zinc ointment. This was an advance, but benzoic acid is itself irritating. The Americans with their usual ingenuity came to our aid, and in cosmoline, a refined derivative from the destructive

\* Introductory Lecture to the Course of Diseases of the Skin in the Extramural Edinburgh, Summer Session, 1881.

distillation of petroleum, we have an almost unchangeable substance, not irritating, and of elegant appearance, which has almost replaced lard in the preparation of ointments. It has however, one fault; it wants solidity, and is often best used in combination. An almost perfect basis for ointments is made by mixing cold cream, made from oil of almonds, white wax and spermaceti, with cosmoline, in suitable proportions. This will scarcely turn rancid, and is solid enough at all temperatures, so that when it is desirable to keep up the action of an ointment for many hours without disturbing the surface, this suits much better than simple cosmoline. Cosmoline is volatile at the temperature of the body, yet when a thin ointment is needed, as in applications to the scalp, there is perhaps no better basis than cosmoline alone.

In many disorders of the skin one of the most troublesome symptoms we have to deal with is what is known as the sensation of itchiness or itching, and could we cure this, the disease itself would oftentimes disappear. Before saying a little on the more recent means of relieving it, let us try to understand what causes it. It must arise from some irritation of the extreme peripheral terminations of the sensitive nerves. Now the medullated nerves distributed to the skin pass through the corium, and either end in special organs, as pacinian corpuscles, the end-bulbs of Merkel, or tactile corpuscles; or, losing their medulla, they form "a sub-epithelial plexus from which certain fibrils enter rete Malpighi, where they branch and form a delicate terminal network lying in the intercellular spaces."\* It would seem that it is these little nerve fibrils which, when their condition of stability is disturbed, occasion the phenomenon of itching. Various conditions may induce this instability; either too rapid a current of blood through the superficial capillary plexuses, as in the sudden hyperæmia of urticaria, may occasion this, or quite the contrary condition—too slow a movement in the venous radicles, as in legs with varicose veins. Certain morbid products or unnatural substances circulating in the blood irritate the peripheral nerve twigs and cause itching, as bile pigment in jaundice of some standing. Some think that it is the bile pigment, becoming oxidised on coming to the surface, which causes this; it rather seems to be due to persistent contact of the bile pigment with the nerve fibrils; hence pilocarpine washing it out from within has been successfully used by Professor MacLagan in icterus, by Simon and others in prurigo and pruritus, where it renders the cells of the rete more succulent and improves their nutrition. In nearly all cases itching is a symptom of superficial irritation. It is met with in healing ulcers when the film of horny cuticle is closing over the granulations and the new and juicy cells are being compressed for the first time from without, or by the conjoined

pressure from within and from without, since the further out-budding of new capillaries, due, as Mr. Hamilton believes, to unresisted pressure from behind, has been prevented. The itchiness of the skin when there are varicose veins or capillaries in the leg, has been most clearly explained and accounted for by Kaposi, an itchiness which in many cases is the first indication of a future outbreak of eczema there. It may be remarked here how very seldom—scarcely ever—any complaint of pain as an accompaniment of eruptions of the skin is made. The nearest approach to it is perhaps the sensation of burning or heat in the early stages of eczema. Pain in the skin only occurs when the sensitive nerve fibrils are continuously compressed by some new growth, as in carcinoma or sarcoma of the skin, which has lasted some time; or when, as in irritable ulcer, a fibril of a sensitive nerve is exposed, probably unprotected by its sheath on the surface. This, as Mr. Hilton has shown, is relieved by finding out the acutely tender part, and dividing the nerve behind it. We have already alluded to the use of pilocarpine in relieving some forms of itching. When, as in urticaria, too rapid a flow of blood through the skin seems to be the cause, all means which keep the body cool diminish this symptom. Hence the value of vinegar or alcoholic lotions, which promote evaporation from the surface, and the disuse of flannel, which, being a non-conductor, hinders exhalation, while its rough texture stimulates the skin and favors congestion. Then we have remedies which coagulate the albumen of the tissues, as carbolic acid and tar, and thus deaden sensation; both penetrate a short way into the epidermis, and while carbolic acid is the more rapid in its action, it is, from its volatility, also the least permanent. Camphor has long been known as an antipruritic of some value, but when combined with chloral hydrate, forming a liquid, its efficiency is much increased. It may be painted on pure, or used diluted with two or three parts of cosmoline. Thus employed it forms one of the best means we possess for the relief of pruritus podicis, when this does not depend on ascariæ or any plainly evident cause. But it occasions pain when applied to a part denuded of epidermis. Itching which owes its origin to too slow a current of blood, of which the most typical example is that seen in eczema connected with varicose veins of the leg—but to the same category also many examples of pruritus scroti, labiorum and ani may be referred—is best relieved by careful flannel bandaging, well applied suspensory bandages, and laxative salts or mineral waters, which unload the rectal veins by freeing the portal circulation, combined locally with weak tarry lotions, one of the best of which is Wright's liquor carbonis detergens, a well-made alcoholic solution of coal-tar, suitably diluted.

We owe to Mr. Balmanno Squire the introduction of chrysophanic acid as our most efficient remedy in relieving psoriasis. Both Mr. Squire,

\*Malcolm Morris. *Skin Diseases*, p. 13.

however, and Dr. James Adams, who wrote an excellent paper on it in the *Edinburgh Medical Journal* recommended much too strong an ointment. Mr. Squire still adheres to a formula of two drachms to the ounce. This may do all very well for some pachydermatous people, whose skins react little to irritants, but in general from ten to fifteen grains in the ounce of cosmoline is potent enough. Messrs. Macfarlane in the North Bridge sent me a specimen of what they called chrysarobin,\* whether this differs in aught from well prepared chrysophanic acid I do not know, but it seemed to me, while equally efficacious in curing (for the time) psoriasis, to be less apt to induce the troublesome and alarming erythema, which so often follows too energetic a use of chrysophanic acid. In employing chrysophanic acid for psoriasis it should be remembered that a little of the ointment well worked into the patches, previously cleared of their scales, does infinitely more good and less harm than a great deal dabbed in. Alizarin, suggested by Dr. Adams as a substitute for chrysophanic acid, on ingenious chemical grounds, does not appear to have found much favor, but pyrogallic acid introduced by Jarisch has been of more value, though not well adapted for application to extensive surfaces. Since it does not irritate and inflame the conjunctivæ, it is better suited than chrysophanic acid for psoriasis affecting the scalp and face, and may be used in the strength of one drachm to the ounce. Besides its value in psoriasis, pyrogallic acid seems also to exert a slowly destructive action on some forms of new growth, especially those which are allied in a somewhat natural class grouped round the sarcomata. These it causes gradually to wither away, and opens up a more hopeful prognosis in the case of tumors so eminently apt to recur as those are. I am inclined to think from my experience of its use that it exerts an influence something like tannin. Under its use the growth becomes smaller, denser, and less apt to bleed, and crumbles away in parts. It irritates the skin round the tumor, so that it must be guarded by covering it with a protective with a hole in it just the size of the tumor.

The flexible collodion of the Pharmacopœia has proved itself useful in many ways. In restraining the advance of erysipelas migrans, more particularly in children, I have often found it of great value. When burns of the skin do not advance beyond the first grade a coating of flexible collodion serves to protect the vesications from rupture, and in no way interferes with treatment by cotton wool. Its applicability to the various forms of herpes is well known, but less so its value in chronic eczema of the palms, where it lessens the itching and helps the fissures to heal. I have not found Ferris's anodyne amyl colloid half so valuable as the simple collodium flexile, while its odor is unpleasant.

The late Dr. Tilbury Fox insisted particularly on the use of soothing remedies in various forms of skin disease where there was irritation to be allayed. These may consist of substances in the state of powder, as the carbonate and oxide of zinc, bismuth, chalk, &c., suspended in water, to which a little glycerine has been added. Glycerine when so used must be the best and purest, free from fatty acids, and must be well diluted. Pure glycerine undiluted is an irritant, freely diluted with water is an emollient, and the best remedy we have for that dry and fissured state of the cuticle occurring in the hands and face and legs during frost or when east winds are prevalent. The same softening effect is produced when glycerine and starch are combined in the glycerum amyli of the Pharmacopœia, the starch here serving both to dilute the glycerine and also to impart its own demulcent properties.

When the epidermis is not renewed with sufficient rapidity, when there is a sluggishness on the part of the skin, the face in particular looks grimy, the complexion has not its healthy transparency. The cause of this is not primarily in the skin; the organs elsewhere of excretion, of secretion, and assimilation are acting badly, and these demand attention and regulation. But we must also act on the skin and its glands; stimulation is required here as elsewhere. The commonest stimulant used is soap, which always contains more or less free alkali. The alkali acts by causing the albuminous tissues to swell up, the cells thus become separated and are thrown off. Alkalies act chiefly on the superficial strata of the epidermis, when, at least, they are only permitted to remain for a short time in contact with them. But the action of acids on the cuticle and rete mucosum has been, until recently, overlooked. Acetic acid in a dilute form renders albuminous tissues transparent, but it has not much effect on the outer horny layer of the epidermis; it appears to penetrate more deeply, absorbs water from the rete cells, and, like the alkalies, induces desquamation, but more gradually, and from within outwards. Unna has very successfully applied this to the treatment of "a bad complexion." Where there is some degree of acne punctata and comedones, he employs a paste consisting of four parts of kaolin, three of pure glycerine, and two of vinegar. When this is smeared on the face under such circumstances, the eyes being kept shut during its application, it dispels the acne and comedones, wonderfully clears up the muddy complexion, and prevents the simpler form of acne advancing to the graver.

Warts on the hands are always disfiguring, apt to become ragged and to bleed, and are very probably contagious: their removal is therefore a matter of importance. Glacial acetic acid, solid nitrate of silver, and other means have been recommended and used, but chromic acid, one to one of water, is by far the best remedy. The skin round each wart is first protected by painting it with oil, and then the wart itself is soaked with

\* *Vide Practitioner*, vol. xv. p. 14, and vol. xiv. p. 45.



the solution of chromic acid; this absorbs water from the tissues, coagulating and hardening the albuminous tissues at the same time, and the unsightly warts soon disappear. These warts seldom appear after puberty on the hands, but a healthy girl, well-grown, aged fifteen, came to me some time since with dozens of them on her hands, which had annoyed her for six years. Of course, they much interfered with work, being always in the way. Steady use of the chromic acid removed them in a few weeks.

Chaulmoogra oil,\* which has obtained a certain reputation in India for the amelioration of the symptoms—I will not say the cure—of leprosy has been introduced into this country with the somewhat vague reputation of being useful in skin diseases. It has answered well in my hands in some cases of eczema of the face which had passed the moist stage and tended to become dry. It seems to act as a mildly stimulating astringent, but its applicability is certainly limited, and experiments with it in Germany recently reported have not increased its reputation. It is in the strumous forms of eczema of the face in children and young persons that the best results from its use have been attained in my hands, and I have also found it of considerable value in the later and scaly stage of eczema of the scalp. The form in which I have used it has been as an ointment in the proportion of a drachm to the ounce of glycerine, of starch, cosmoline, or simple ointment.

The subject of parasitic diseases of the skin has received considerable attention, and also some elucidation of late. Favus has become so rare, and the treatment has been so thoroughly settled, that allusion need not be made to it, and tinea versicolor, though fairly common, is easily cured. But there are two varieties of tinea tonsurans at least which still prove intractable, and to the recent deliverances on these I wish to ask your attention for a little. We only occasionally, and then mainly as a transplanted exotic, meet with tinea trichophitina cruris, the so-called eczema marginatum, where the parasite finds a favorable nidus and suitable conditions for its growth in the warm and moist situation of the inner surface of the thighs and the adjoining parts of the scrotum. There seems to be no better antidote to its luxuriance than freshly prepared sulphurous acid as recommended by Dr. Bulkely. It is of much importance that the solution of sulphurous acid should be fresh, since by exposure to the air, or when long kept, at least unless in a well-closed stoppered bottle, the acid partly becomes weaker from escaping from the water in which it is dissolved, partly becomes oxidized into sulphuric acid, which is an irritant and not a parasiticide. The sulphurous acid sponged freely on the parts several times a day soon lessens the itching, and eventually cures the disease. Any excess of irri-

tation caused by the acid subsides when the use is discontinued for a day or two and some soothing ointment or lotion substituted for it. But while we only occasionally meet with examples of this form of ringworm, nothing is more common than tinea tonsurans of the head in children. When early seen such are in general easily cured by blistering with acetum cantharidis, by the use of glacial acetic acid either pure or slightly diluted with spirit and glycerine, or by Coster's paste—iodine dissolved in colorless oil of tar. But it is far otherwise when the disease has been neglected, or when, owing to some peculiarities to be alluded to immediately, it has obtained a firm hold on the skin. Sections of the skin from parts affected with ringworm have rarely been obtained. Dr. Thin, from observations made on the skin of a horse, concluded that the parasite lived exclusively in effete epithelial structures. Dr. Robinson, of New York, in a paper published in the *New York Medical Journal* for March, describes and figures the appearances found in skin from tinea tonsurans of the head, and has found the parasite in the corium, the hair-bulb, and even the subcutaneous tissue. He concludes his paper in these words: "The anatomical seat of the fungus in tinea tonsurans capillitii is different in cases of disease. It may be seated only in the corneous layer, or it may extend even to the subcutaneous tissue. Probably in those cases in which a large number of hairs fall out entire, the fungus extends deeper than in those cases of only stubbed hair. The deep seat of the fungus in some cases is probably the cause of the occasional obstinacy of the disease and difficulty of cure." When the resistance of the tissues is lowered by anæmia, or by the condition we term tuberculosis or scrofulosis, it is easy to understand that the spores and mycelium will make their way further and without inflammatory reaction. The great difficulty in the treatment of ringworm of the head has been that the agents employed for its cure did not penetrate deep enough to reach those outlying spores which were always ready to germinate and reproduce the disease. Evidence has recently been accumulating to prove that for many of those rebellious cases we possess in the oleate of mercury a reliable parasiticide. Dr. Alder Smith recommends it in such cases, and says that only once did he see slight salivation produced by its use. In one of Dr. Robinson's cases, where the fungus was proved by the microscope to be deeply seated, five or six applications of a 6 per cent. solution of oleate of mercury cured it, though it had lasted for four months. We may assume, then, that the oleate of mercury used cautiously is a remedy for tinea tonsurans of considerable penetrating power. But there still remain some cases which resist all the measures usually employed, and for these Dr. Alder Smith has recommended croton oil painted on these patches sufficiently often to produce a pustular eruption, resembling what has been known as kerion in at least one of its forms. When this

\*Vide *Practitioner*, vol. xxi. p. 321.

is done not only do the hairs become loosened and fall out, carrying with them much fungus growth, but the inflammation extends beyond the follicles into the perifollicular tissue and destroys the vitality of the outlying and deep-seated spores, and renders the tissue no longer a fit soil for their growth. One other remedy for tinea tonsurans needs a single remark, viz., turpentine, which Dr. Foulis has found so useful. In my hands, used as he has advocated, I have thought it an adjunct to other means, but not in itself and alone curative.

Besides the use of medicinal agents in diseases of the skin, various operative measures have been of late employed in some forms, and these demand a share of attention. Chief among these is that of scraping by means of the sharp spoon or dermal curette, introduced by Volkmann of Halle. The value of this mode of treatment in suitable cases and forms of disease can scarcely be over-estimated. Take lupus, for example. Till recently our means of local treatment consisted in caustics and the galvanic cautery, to which may now be added the thermocautery of Paquelin. With two exceptions all the caustics and the cauteries did too much. Tissues still uninjured by the new cell-growth were destroyed along with it, and hence there arose a scar, depressed and tending to contract much, causing additional disfigurement to that already inflicted by the ravages of the disease. Nitrate of silver and arsenic alone act on the cell-growth itself, and leave unaffected the healthy tissues. But the former, though well suited for small nodules of lupus, is a slow and superficially acting caustic, and thus further ravages were made while the curative treatment was progressing. Arsenic again is a painful caustic, cannot be applied to large areas for fear of absorption and toxic action, and has thus found more favor with quack cancer curers than with the medical profession generally. Mr. Marsden has done much to bring it into favor, but not very successfully. And Hebra himself, who spoke much in its praise, did not latterly extensively use it. The spoon has this great advantage, that the surgeon while using it can tell exactly by his sense of touch when the limits of disease have been reached, and healthy or little diseased tissue is being encroached on. The diseased parts in lupus break down with the utmost readiness under the spoon, while the sound parts offer an almost unconquerable resistance. Indeed with the spoon one can scarcely do too much, one is far more likely to accomplish too little. The cell-growth infiltrating itself along the vessels, penetrates beyond the reach of scraping, and thus demands other measures for its removal. Though a painful operation at the time, necessitating the employment of anæsthetics for its efficient performance, the pain ceases at once after scraping has been discontinued. It is a bloody operation, but the bleeding is arrested with the utmost ease by pressure. A thin slough separates, then a clean healing surface is left,

which generally cicatrizes over readily. Islets of disease are left here and there, however, at the margins of the patch, and within its area, where the cell-growth has penetrated more deeply, perhaps along the vessels of a peri-glandular plexus, or by the communicating vessels which unite the superficial and deep horizontal layers of cutaneous blood-vessels. These are best treated by making many minute punctures with a fine knife, which stimulates absorption by causing small hæmorrhages into the tissue. These occurring suddenly excite the tissues to reaction, as an effect of which blood-clot and cell-growth simultaneously are removed. The scar resulting from a successful scraping is smooth, soft, and little, if at all, depressed below the skin which surrounds it. Equally well suited for scraping are the superficial epitheliomata of skin and accessible mucous membranes, as the lip. In this way the early stages of rodent ulcer can be most satisfactorily treated. These forms are usually long, many years often, before they infect the lymphatics, and may be radically cured by scraping. I have in this way treated several cases of rodent ulcer on the upper part of the face and epithelioma of the lip without recurrence, though years have passed, while the resulting cicatrix was in every way satisfactory. Primary sarcoma of the skin, a rare disease, can be treated by scraping, but, from the nature of the morbid growth, relapses are more apt to occur than in superficial epitheliomata. In spindle-celled sarcoma, too, the growth resists the spoon, and is by no means so readily removed. It is the custom of some American dermatologists to sear the raw surface with the thermo-cautery after scraping lupus. I have no personal experience of this, but it is certain that there is here again the risk of doing too much by destroying minute areas of healthy tissue, while even in this way we cannot follow the finer ramifications of the disease. The application of a strong solution (forty grains to the ounce) of chloride of zinc to the scraped surface may possibly have some advantage, since it has some penetrating power, but it gives rise to acute biting pain for hours, and does not certainly preclude relapses.

Small fresh spots of lupus, appearing as little red jelly-like nodules rising up from the corium through the epidermis, are admirably treated by the plan suggested by Auspitz. A thickish needle or his puncturing instrument is dipped in iodide of glycerine, one in twenty, and this is plunged into the nodule; slight inflammatory action is set up, and the lupus deposit withers up and disappears, leaving scarcely a trace.

There are perhaps no more unsightly blemishes than the so-called mother's marks, port-wine marks, and flat nævus vascularis, which are so frequently met with in the face. I leave it to obstetricians to explain why these should in a large proportion of cases occupy the left side of the face. I cannot give the statistics, but any one may satisfy himself of this by noting the persons

affected with this whom he meets in the street. Were we able to remove these marks, or even to convert the red or purplish stains into a white surface, we should have no lack of candidates to be operated on, and it almost seemed, a couple of years ago, that this was in a fair way of being accomplished. Mr. Balmanno Squire about that time announced that he had, by means of multiple and repeated fine linear scarifications, obliterated, or nearly so, one of those marks. Mr. Squire based his suggestion on the fact that such multiple scarifications were of value in the acquired telangiectasis met with in acne rosacea, where the dilated vesicles withered up and disappeared under their employment. The linear incisions were to be made, according to Mr. Squire, at different angles to each other at each repetition of the operation. Such a simple mode of procedure, and which promised so much, was soon extensively tried, and among those who adopted it were Dr. McCall Anderson and Mr. Malcolm Morris. Both unhesitatingly condemned it,\* not only as useless, but as positively injurious, since Mr. Morris found that not only did he not cure his patient after more than a hundred sittings, but some nodules of cicatricial keloid arose, a result which might almost have been predicted. Mr. Squire then said in a second communication that by making the incisions obliquely instead of vertically to the plane of the skin, obliteration of the vessels could be affected. I tried both plans fairly, and can say that, so far as my experience went, no effect whatever was produced on the nævus. I fear, therefore, that we have here to do with a case of too-hasty generalization. Some cases of port-wine mark may, however, be treated with a fair degree of success by a method recommended by Dr. Sherwell, called by him tattooing. This consists in pricking the surface freely with a bundle of needles dipped in carbolic or chromic acid, of a strength of from 25 to 40 per cent. The surface is then dried and sponged with alcohol, and a thick layer of collodion painted on. The operation is neither painless nor instantaneous, requiring to be repeated at intervals of some months, and sometimes leaves a scar; still it appears the best method yet available. The varicose capillaries in rosacea and acne rosacea can undoubtedly be much diminished both in number and calibre by various modes of treatment. One of these is by splitting them up longitudinally as recommended by Dr. Liveing, a fine narrow knife being used. This succeeds best with the larger vessels. The smaller can be punctured with a star or diamond-shaped, or rather headed, needle, as used by Hebra and Kaposi; this lacerates the vessel and destroys its continuity. We can thus obtain considerable diminution of the redness, but the results are not always so permanent as is to be desired.

Another mechanical agent in the treatment of

skin diseases of recent introduction is the solid India rubber bandage introduced by Dr. Martin. These bandages have been specially recommended as curative in eczema and ulcers of the leg. I cannot say much about the latter, but have used them to some extent in eczema. When used for this they act much like a poultice, the cuticle is macerated and removed, and the surface becomes smooth and clean. Some cases of eczema of the legs can be cured by their use exclusively, others certainly need other and additional treatment, and some they do not suit at all. When the eczema has been of some duration, the limb œdematous and the cuticle thin and friable, vesicles and bullæ, often accompanied with considerable pain, are apt to make their appearance, necessitating the abandonment of the India rubber bandage at least for a time, and the substitution of a cotton, one, or at least of thin muslin beneath a roller of domette flannel. I am sure Dr. Martin is right in insisting on the purity of the rubber used. Whether bandages of as honest a texture as his own are now made in this country I do not know; when Dr. Martin's were first introduced they certainly were not, and as his are now only half their original price, and as good, I make a point of using them.

In these remarks it has been my object to show that the department of skin diseases has, like other branches of medicine, been advancing. We have certainly not succeeded in transferring those affections from the incurable to the curable class in anything like all cases, but I can claim that we are now able to employ our remedies with greater precision and certainty, while the list of those available is constantly receiving accessions of real value.—*Practitioner.*

## THE TREATMENT OF THE NIGHT-SWEATING OF PHTHISIS.

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Sweating in phthisis is both an annoying and a serious symptom. It very often happens in the early morning hours, and the patient is languid all day from the drain. It may follow the decline of the paroxysm of the hectic fever, but also occurs in those who have but little if any fever, and certainly nothing like hectic paroxysms. To arrest it is not only to give the patient comfort, but to save his strength and thus to retard the progress of the disease. The remedies which influence the destructive malady and improve nutrition, restrain it; but they do so slowly, and we turn, therefore, naturally, to agents which, while they act much more quickly, in so doing assist at the same time the influence of the general treatment. A great many of these remedies are empirical; some take into account the supposed pathology of the sweats,

\* *British Medical Journal*, vol. ii., 1879, p: 293:

and apply the fine experimental therapeutical research of the laboratory to the benefiting of a serious symptom. We might do this with even more accuracy if the pathology of the occurrence were better understood; if it were known how it is that the morbid conditions act on the sweat-centres which are so profoundly disturbed. Yet both physiology and pathology are, in this matter of sweating, alike in health and in disease, still a good deal in the dark.

I shall select for discussion the action of such remedies as are valuable yet comparatively new, and not of such tried veterans as oxide of zinc, the mineral acids, tincture of iron and decided doses of quinia.

Yet, before I examine into the value of the medicinal substances I will allude to some subjects connected with clothing and with bathing, which I know are constantly ignored and are yet of importance. The clothing is often much too heavy. I wish then to impress upon you that one of the first things to be taken care of in the management of night-sweats is to see that the patient's clothing is light, particularly that he be not weighted down with heavy bedclothing; and very often you may, by paying attention to this simple means, prevent or certainly very much lessen the exhaustive perspirations. In addition, direct your attention to the state of the skin; let the patient take a daily, slightly astringent sponge-bath, having in the water alum, rock-salt, or even whisky or alcohol, or let him be sponged with quinia dissolved in whisky or alcohol, or with water, to which a small amount of solution of ammonia has been added; and follow this by friction to give a healthy glow to the skin. You will find that in some persons very hot water checks the excessive sweating, but in the majority moderate friction, following astringent washes, is better.

In reviewing the remedies with which the last few years have made us familiar, we find quite a number with which the experiments and the sagacious observations of Dr. William Murrell have acquainted us. *Muscarine* stops sweating on the second or third night, without causing abnormal dryness of the skin. It is best given in three doses, at the interval of an hour, in quantity not less than five minims of a one per cent. solution of a liquid extract. *Picrotoxine* produces, generally, no effect the first night; may be given solely at bedtime, either in pill of one-sixtieth of a grain, or in solution with a little glacial acetic acid. *Nitrite of amyl*, a good, though not a very certain or pleasant agent. Dose from one to three minims.

*Dover's* powder, although it cannot be called a new remedy, since its use was advocated many years since by Stokes, has come again into prominence, and in doses of two to ten grains at bedtime undoubtedly shows power in controlling colliquative sweats.

I shall presently explain to you how I have for some years used *jaborandi*, added in small doses to atropia, to correct some of its unpleasant effects.

And it was while so using it that I began to be aware of its influence on night-sweating of phthisis. Dr. John M. Keating, prescribing it in small quantities of the infusion, finds it answers extremely well; he believes that it contracts the capillaries, and thus explains its action. Dr. William Murrell, whom I have already quoted, has administered it or pilocarpine in thirty-three cases, in all stages of the disease. Of pilocarpine the dose employed was generally  $\frac{1}{6}$  of a grain, either at bedtime or three or four times daily. It acts somewhat slowly, but is said to be very efficacious and even to lead to permanent results. I confess that I have not formed so high an estimate of it. Indeed, I cannot say that, given by itself, it ranks with me very high.

*Salicylic acid* has attracted attention more for its supposed influence on the febrile conditions of phthisis than as a remedy for the sweating. Still it has been so employed. Kohnhorn has recommended dusting with salicylic acid three parts, ten of starch and eighty-seven of talc earth, the entire surface of the body. Internally salicylic acid has been resorted to for night-sweats by my colleague Dr. Hutchinson, and from him I learnt its use for that purpose. In some cases it seemed to have a good influence, but the cases are not yet numerous enough to warrant a definite conclusion as to its merits.

I was led to use *physostigma* for the same reasons which led me to investigate *jaborandi*, to try and counteract with it some of the disagreeable effects of atropia, while preserving its useful ones. But in doing so it was first necessary to observe whether calabar bean had in itself any influence on night-sweats; and during the winter of 1879-1880, with the active and zealous aid of Dr. Henry M. Wetherill, at that time the resident physician in my wards, we tested the matter in this Hospital. We found that calabar bean had an influence. To cite a few of the observations: In a man with advanced tubercular consumption, attended with profuse night-sweats, two minims of fluid extract of *physostigma* were given; he was sweating at the time; his respirations were 30, the pulse 120, the temperature 100°. In an hour afterwards the skin was almost dry; respirations were 24; the pulse was 104; the temperature 96.6°; it rose in two hours after this to 97.8°. There had been no unpleasant effects, except great thirst. In another case we first noticed the sweating carefully, while a placebo only was given. It came on profusely at 12 p.m., and while profuse, the respirations were 32, pulse was 122, the temperature 97°; the sweating lasted four hours; as it passed away, the respirations were 28, the pulse 114, the temperature 99.8°. At the same period of the next twenty-four hours, and when the sweating had fairly begun, although the temperature then was 99.5°, a dose of two minims of the fluid extract of calabar bean checked the sweating in an hour and a half, the temperature rising to 100.6°. In a third case of marked phthisis with night-sweats,

the temperature before the sweats at 3 p.m. was  $100.5^{\circ}$ ; in an hour afterwards, with a profuse sweat it had declined to  $98.6^{\circ}$ ; four minims of the fluid extract were then given, the sweat was completely checked in an hour, the temperature rising to  $99^{\circ}$ ; there was no decided effect on the pupil, and no unpleasant symptom. In a fourth case, the profuse early morning perspiration, were arrested in two hours by the same dose, the pupils being slightly contracted, the pulse becoming less strong; the temperature declining from  $100^{\circ}$  to  $97.6^{\circ}$ . Now both in these and other cases the remedy was given in two minim doses, once or twice in the evening, sometimes four minims at one dose (the preparation being of the strength of one of the bean to a minim of fluid), and the sweating was undoubtedly to a great extent prevented; but only in one instance was the effect at all permanent; and on the whole, while the action of calabar bean is undoubted, it is decidedly inferior to atropia and to ergot.

I shall now pass to the two remedies which I think preëminent—atropia and ergotine. The use of *atropia* is now so widely known, and it has been so much resorted to that, although having employed it systematically in this hospital for night-sweats for years before it began to attract general attention we may claim for it the strong partiality of early knowledge. I shall only state that it is at present accepted as the most potent agent we possess to control inordinate sweating, particularly in consumption. Not one of the remedies which I have mentioned to you has, in my opinion, anything like its power. But atropia has a most serious drawback. Even the smallest dose, to be effective,  $\frac{1}{2}$  of a grain, produces such a dry mouth and throat that it often keeps the patient awake, and, in not a few instances, increases his cough. Duboisia, so much like atropia, even in its influence on sweating, has the same unfortunate effect. Local remedies, such as sucking pieces of ice, chewing chamomile flowers or sassafras pith, sipping infusions of slippery elm, only afford partial relief, moreover they prevent sleep. And the inconvenience witnessed led me to a series of observations that I have here carried on for the last four or five years to find, among the agents which possess a physiological antagonism to atropia, one which, without materially, if at all, diminishing its action on the skin, might mitigate its influence on the salivary secretion. Not to detain you too long, I will speak particularly of strychnia, calabar bean and jaborandi, added to belladonna or atropia. With reference to strychnia, it is in many respects not antagonistic to belladonna; one, indeed, may promote the activity of the other; and I was led to hope all the more from a combination being effective with a smaller dose of the belladonna or atropia, and was induced to persevere with my observations after reading Lauder Brunton's remarks on the unaided action of strychnia in the night-sweating of phthisis. But this expectation has only been

partially realized. The atropia preponderates, and even in decreased doses dries the throat.

From both calabar bean and jaborandi we get better results. I have already laid before you my observations with the former given alone, and you will recall the fact, which has been made very apparent by the experiments of Fraser, Bartholow and other investigators, that in most respects it is a true antagonist to atropia. It leads to an increased flow of saliva, and is said to increase the perspiration. But it certainly does not do so in phthisis, whatever be the explanation; and if you add gr.  $\frac{1}{4}$  to gr. of the solid extract, or two to three minims of the fluid, to  $\frac{1}{8}$  or  $\frac{1}{6}$  of atropia you preserve or heighten the good effect of the latter and lessen its evil ones. Still better I find is jaborandi. The drug, you are aware, illustrates in its action a complete antagonism to atropia and produces profuse secretion from the salivary glands. Yet, though in health it promotes the most active discharge from the skin, its powers in small doses to arrest morbid sweating have been abundantly proved, and added in small doses to atropia, say ten to fifteen drops of the ordinary fluid extract to  $\frac{1}{8}$  of a grain, or, as I have often done, a dose of this quantity given two hours in advance of the atropia, and repeated with it, the sweats will be as well influenced, while the discomfort arising from the dryness of the mouth will be greatly diminished. The effect of the combination is undoubted, and its power is not confined to the night perspirations of phthisis.

Still we cannot, even by the combination of jaborandi with atropia, always remedy the annoyance. It is difficult to hit upon the exact dose, and the atropia will at times overpower the jaborandi. I have thus been led to look for an agent which should possess something of the certainty and permanence of action of atropia without its drawbacks, and I think I have found it in *ergotine*. My first observations, made some years ago, were with the fluid extract of ergot, but I have abandoned this for ergotine as better and more easily administered. The power ergot has of contracting the arterioles and of checking excessive discharges suggested its use, and the results have been very satisfactory. The dose of ergotine I employ is usually two grains three or four times daily, and by the second night the influence begins to manifest itself. The remedy may then be continued and gradually abandoned; it produces no annoyance or discomfort whatever, and its good effects persist after it is withdrawn. It will fail or lose its effect as every other remedy will fail or lose its effect in the treatment of such an unrelenting disease, but the proportion of failures is small compared with that of the successes.

You will ask for a comparative estimate between it and atropia. For immediate results ergotine is far inferior. If you see a patient in the morning, in whom you wish to prevent a violent sweating in the evening, there is no remedy which for promptness can compare with atropia; there is

moreover, no remedy which is so potent in cases where the skin pours forth quantities of fluid. But where such speedy and decisive action is not demanded, where you are obliged to keep up a remedy for some time, where to do so with atropia becomes very difficult or occasions first discomfort and then actual distress, you have then, in ergotine, an agent to which you can turn with confidence. Less prompt, perhaps less certain, it is better borne, and shares with atropia the valuable power of often making a durable impression. Nay, I have seen it do so when atropia has failed.

Gentlemen, I have now laid before you the results of a series of inquiries into a matter of deep and practical interest. In summing it up in your minds you will see that there are many articles, some of which do the work required of them well, other not so well. It is not easy to say which agent in a given case will succeed best, and you ought to be as accurately as possible acquainted with the action of many. Speaking generally there are remedies which act as astringents and as arresting the secretion; there are others which, under normal circumstances, promote perspiration and allay the morbid sweating, either because they substitute a normal discharge for an abnormal one, or, what is more likely, because given in small doses they tone up and gently stimulate to healthy action the sweat-centres and the respiratory centres. But, whatever the explanation, the latter class of remedies, Dover's powder, jaborandi, picrotoxine, are on the whole, greatly inferior to the former, and not so permanent. And it is permanency of action at which we must, as far as possible, aim. This gives time for the general treatment to take effect; it arrests a serious drain, and, what I have endeavored to show you in the case of several of the agents, if we once succeed in making for more than a very short period a decided impression, the annoying, dangerous symptom may be altogether relieved or at least forever broken in intensity.—*Medical News and Abstract.*

## THE TREATMENT OF ACUTE RHEUMATISM.

By ALFRED STILLE, M.D.

The treatment of simple acute articular rheumatism may be abandoned to palliatives and nature. Apart from complications, such cases nearly always recover under rest and careful nursing. Try and disabuse yourselves of the idea that their cure is dependent upon medicines alone; to help nature is often the best we can do. No treatment was ever invented which stopped a case of acute articular rheumatism. It cannot be stopped by bleeding or sweating or purging, by nitre, by tartar emetic, by guaiacum, by alkalies, by salines, by salicylic acid, or by anything else. The physician can palliate the pain and perhaps shorten the attack, can control and perhaps prevent complica-

tions and stiffness of the joints, but he cannot arrest the disease. Where rest, proper diet, and warmth are enjoined, most cases will get well just as soon without as with the use of medicinal methods. Purgatives have been used in all ages in the treatment of this disease, because it was thought to be a fever. We are all but too ready to put our necks into the yoke of a theory. In old times they thought that the system ought to be reduced. Before the time of purgatives depletion was employed. This mode of treatment I will not even discuss. There is no evidence of which I am cognizant in favor of purgatives. There are very good reasons, indeed, why they should not be used: (1) Because they cannot possibly cure; (2) because they oblige the patient to make painful movements; and (3) because they expose him to the dangers of cold. There are certain cases in which purgatives are alleged to be of use, viz: those in which the bowels are constipated, and there is a bitter taste in the mouth. I have never seen such cases except in habitual drunkards, and in such patients a purgative does more harm than allowing the effete matter to remain in the system. Opium was once vaunted as a specific, and it was claimed that it diminished the tendency to complications in the course of the disease. More recent experience has shown that opium, of all remedies, is the most likely to cause heart complications. Some have recommended colchicum, arguing that because it does good in gout, it must, therefore, do good in rheumatism. But colchicum is not a remedy for rheumatism. Many years ago it was very much the custom to administer large doses of powdered Peruvian bark. The rationale of these large doses was founded upon their sedative effect. Never was there a more profligate waste of a precious medicine. I believe that it has also been fashionable in the so-called cases of hyperpyrexia to immerse the patient in a bath varying in temperature from 60° to 98° F. Although patients thus treated sometimes recovered, they also sometimes perished from congestion of the lungs and brain.

Among cardiac and nervous sedatives, digitalis, veratrum album and viride, veratria and aconite, have each, at one time or other, been employed indiscriminately. Such treatment, of course, has only proven itself to be a monument of rashness to those who employed it.

Within the last few years new remedies have been proclaimed in the shape of salicylic acid and its sodium salt. I confess that I possess no personal knowledge of their use in this disease, for I was at first dissuaded from employing them by a prejudice against the grounds on which they were recommended, and more recently by the contradictory judgments respecting them, and the unquestionable mischief they have sometimes caused.

It may be difficult to see the connection between blisters and alkalies in their power to influence the course of acute articular rheumatism, and yet it is certain that they do so influence it, and in

the same way, *i. e.*, by altering the condition of the blood from acid to alkaline. If you ask me to explain to you how blisters act in this way I am obliged to confess my ignorance. To produce this result they must be applied over all the affected joints. Experience, if not science, has decided conclusively in their favor. They do effect a cessation of the local symptoms, render the urine alkaline, and diminish the amount of fibrine in the blood.

This brings us to a consideration of the use of alkalis. Alkalis neutralize the acids, act as diuretics and eliminate the *materies morbi*. Alone, and in small doses, they are unable to influence the course of the disease; but when given in very large doses their effects are marvelous; the pulse falls, the urine is increased in quantity and becomes alkaline, and the inflammation subsides. The symptoms of the disease are moderated, the duration of the attack is shortened, and the cardiac complications are prevented. The dose of the alkalis must be increased until the acid secretions are neutralized. A very good combination of these remedies is the following:

R̄. Sodæ bicarb.....	3	iss.
Potas. acet.....	3	ss.
Acid. cit.....	f. 3	ss.
Aquæ .....	f. 3	ij.

S.—This dose should be repeated every three or four hours, until the urine becomes alkaline. On the subsidence of the active symptoms two grains of quinine may be added, with advantage, to each dose. The alkalis must be gradually discontinued, but the quinia continued. The diet should consist of beef tea or broth, with bread and milk; no solid food should be allowed. Woollen cloths moistened with alkaline solutions may, with advantage, be applied to the affected joints. To these laudanum may be added for its anodyne effect. The patient must be sedulously protected from vicissitudes of the temperature, and be in bed between blankets. The alkaline treatment relieves the pain, abates the fever, and saves the heart by lessening the amount of fibrine in the blood. A long time ago Dr. Owen Rees, of London, introduced the use of lemon juice. This remedy was thought to convert uric acid into urea, and to so help elimination. Though the treatment is practically correct, the theory of it is all wrong. Lemon juice does good in mild cases, but cannot be relied upon in severe attacks. During the febrile stage of acute articular rheumatism the diet should consist mainly of farinaceous and mucilaginous preparations, with lemonade and carbonic acid water as drinks. The cloths applied to the joints should be changed when they become saturated with sweat, and in changing them the patient should be protected from the air. The sweating may be controlled by small doses of atropia, from the  $\frac{1}{6}$  to the  $\frac{3}{6}$  of a grain. To prevent subsequent stiffness, the joints should be bathed with warm oil and chloroform, and wrapped in flannel cloths.

In the proper season the condition is very well treated by sea-bathing. There is no specific plan of treatment in acute articular rheumatism. The treatment pursued must vary according to the intensity of the inflammation and the peculiarities of the patients.—*Medical Gazette*.

## TREATMENT OF SECONDARY PUERPERAL METRORRHAGIA.

By THEOPHILUS PARVIN, M.D.,

Professor of Obstetrics and Gynecology, University of Louisville. From *Gynecological Transactions*, Vol. V.

*Uterine Compression*.—The first impulse of the practitioner called to a case of puerperal hemorrhage is to place his hand upon the abdomen and ascertain the state of the uterus as to contraction or relaxation, not that commonly in secondary hemorrhage there is an accumulation of blood in the uterus, for usually this is an open, not a concealed, hemorrhage, but to secure, if need be, the final uterine hemostatic uterine contraction. Where compression is necessary the hand may be applied solely through the abdomen, or with one hand thus used and two fingers of the other hand making counter-pressure upon the posterior portion of the cervix.

*The Tampon*.—In the classic monograph of Leroux, written more than a century ago, it is stated that the most certain way of arresting uterine hemorrhage is by pieces of linen or tow dipped in pure vinegar with which the vagina is packed or sometimes these pieces are placed in the womb. Leroux asserts that the vinegar is both *antiputride* and *antiphlogistique*.

But may not the tampon convert an open into a concealed hemorrhage, and thus in no wise diminish, but rather increase, the peril of the patient, in that it induces a false security? The story which Baudelocque narrates is in point: A practitioner, whose patient was in danger by reason of puerperal hemorrhage, could find nothing at hand for a tampon; so he jerked off his wig, tore it in pieces, and thrusting them into the vagina arrested the external flow, but the internal hemorrhage was mortal—he had vainly sacrificed his wig.

Never tampon if the uterus can contain an amount of blood sufficient to endanger life, was the common teaching of our student days. Hervieux, as I have said, almost entirely denying secondary uterine inertia, admits mechanical distention. Practically the result is the same whether we attribute it to inertia or call it mechanical distention. The case of Madame Lachapelle and that of Dr. Maxwell prove that there may be complete uterine relaxation several days after parturition. Thus, then, if we obey the rule given a moment ago we must not use the tampon in most cases of secondary hemorrhage. But is the rule wise? McClintock used the tampon successfully in one case twenty-four, and in another twenty, hours after delivery.

When manual abdominal compression of the uterus is maintained the tampon can not be a dangerous, but will often prove a most efficient, means of treating a serious secondary hemorrhage.

*Compression of the Abdominal Aorta.*—This probably was first advocated in 1797 by Rüdiger, an obstetrician of Tübingen. His method was by the hand introduced into the uterus, pressing through its posterior wall upon the vessel. Ulsamer in 1825 made known the method of abdominal aortic compression; it was strongly indorsed in 1828 by Siebold, from his own personal experience; and Baudelocque was its warm advocate. Dr. Barnes reckons it only a momentary resource. But it will be remembered that in Duhamel's case, previously referred to, the compression was kept up five hours and was successful. Dr. L. Gros has given nine cases of puerperal hemorrhage in which aortic compression was successfully used. Very able theoretical arguments have been made against aortic compression, but stronger than them all is the simple fact that it has succeeded in some most serious cases. Of course, that it may be done efficiently the compression must be performed alternately by two or three, for the compressing hand needs rest after twenty or thirty minutes. However this method becomes less likely to be available the more remote the hemorrhage is from parturition, while the abdomen of the newly delivered woman is peculiarly favorable for it.

*Uterine Injections.*—Leroux states that Galen is almost the only one of the ancients who recommended them, and he further mentions his having thus cured a hemorrhage which had lasted four days. According to Leroux also, Prosper Alpinus, of the University of Padua, cured his wife of metrorrhagia by injecting the uterus with a decoction of Arabian acacia in wine. Andrew Pasta, 1750, advised, in extreme cases of uterine hemorrhage, injection of oil of turpentine, of nitric, sulphuric, or of hydrochloric acid, under the name of stimulants for uterine inertia. Then in the present century followed injections of the salts of iron, of gallic acid, of tannin, of cold water, of vinegar and water, of tincture of iodine, of alcohol and water, and finally of hot water.

It may be conceded that uterine injections carelessly given have been followed by the most serious consequences. But adopting a comparison used by a recent French writer in regard to another matter, must we reject the bistoury because it has been thrust into an aneurism for an abscess? So, too, it is known that injections into the uterus—iodine and tannin as well as iron—even when carefully made, have been followed by severe shock or by dangerous pelvic inflammation, or by death. But are we to renounce anesthetics because now and again, notwithstanding the wisest precautions, an anesthetized patient dies? Some risk may always be run whenever a great immediate peril is to be removed.

Granting, then, the propriety of uterine injections

in grave cases of puerperal hemorrhage, what shall we use? Cold water? It has the advantage of being always available, but, as a direct hemostatic, it is powerless, and only does good by inducing uterine contraction. Moreover, it probably must be used in considerable quantities, and the condition of a patient with her clothing and that of the bed soaked with water is by no means conducive to rest. Still more, the depressing influence of cold may in some cases be dangerous. Madame Lachapelle recognized such danger when the applications of cold water were merely external, remarking that these means ought always to be regulated by the violence of the accident and the forces of the patient, stating that a very feeble subject may be thrown into a mortal prostration by too great cold.

Shall we use hot water? Here again we have means generally available, and not likely to produce either the shock or prostration that cold may. But hot water as a hemostatic proves its utility more especially in cases when there is oozing from small vessels that have been cut or ruptured, and when it does good in the arrest of grave puerperal hemorrhage, this must be accomplished by exciting uterine contraction. In choosing between hot and cold water certainly the preference should be given the former.

But the injection oftenest used, and that which is regarded with the most favor, is of a solution of one of the salts of iron, the perchloride being that which has been especially advocated by Dr. Barnes, the great English representative of this practice. The only substitute for the iron injection that has been brought prominently before the profession is that of iodine. This, originally proposed by Dupierris, in 1857, has been ably advocated by Dr. J. D. Trask. But as Dr. Barnes said in reference to injections of iodine, in 1876, so it may be said now, "the amount of evidence is still too small to justify a decided opinion." At the meeting of the Obstetric Section of the British Medical Association, a year ago, Dr. Barnes reported a case where injections of iodine, then of hot water, failed to arrest a uterine hemorrhage, which yielded to the iron injection. The chief argument made by Dr. Trask against injecting a solution of iron is the production of septicemia, but in answer to this Dr. Barnes, whose experience as to this injection certainly is very great, declares that he has seen "no case in which septicemia could reasonably be traced to the practice."

The strength of the solution advised by Dr. Barnes is one part of the liquor ferri chloridi fortior to three of water.

Hervieux states that for several years he has been using, for puerperal hemorrhage, uterine injections by means of a sound with a double current; that having made them hundreds of times he has not had a single accident; and that caustic solutions injected with proper precautions have for their ordinary, if not constant, effect the arrest of the hemorrhage, either by causing uterine retraction or by coagu-



lating the blood at the place of exit from vascular orifices. The following is the formula for the iron solution he uses. It will be observed that it is stronger than that advised by Dr. Barnes, but rendered less irritating by the addition of sodium chloride :

Chlorure de sodium pur..... 15 grammes ;  
 Solution de perchlorure de fer  
 neutre à 30° ..... 25 grammes ;  
 Eau distillée ..... 60 grammes.

Let the precautions so strongly urged by Dr. Barnes be faithfully observed—such as completely emptying the uterus, whether of clots or placental fragments, of making the injection slowly and directly upon the bleeding surface, and of securing free exit from the uterus, and the perils attributed to the iron solution, either conjectural or actually observed, are prevented ; especially there can be no considerable clot to distress the patient, or by its subsequent breaking down become a source of septic infection, no fragment of placenta to produce a similar infection ; and these conditions were found in two of the cases terminating fatally which have been advanced against the practice. Where injecting the uterus is feared, the styptic may be used to saturate a sponge or portion of cotton wool, and this be carried into the uterine cavity and applied to the bleeding surface. This plan was resorted to by Schreier as early as 1854, and is highly commended by Dr. Wynn Williams, Winckel, and others.

Having considered the chief means resorted to for the arrest of dangerous puerperal hemorrhage, I shall briefly refer to some other means, less important indeed, but often of great value.

*Cold*.—Cold water poured from a pitcher upon the abdomen, after the manner of Gooch ; ice to the abdomen, in the vagina, in the uterus : flapping the abdomen smartly with the corners of a wet towel, as advised by Barnes ; ether-spray upon the abdomen as used by Broadbent and Hicks, etc. All these means do good if the irritability of the uterus can be evoked. But if that be lost by the exhausting flow, they are powerless ; and in no case should they be persisted in to the neglect of more powerful means, if the uterus makes no prompt response.

*Ergot*.—The stomach may be so irritable as to reject it ; and besides, the battle may be lost while waiting for the reinforcement to arrive, the patient die before the medicine is absorbed, especially as absorption is at its minimum in such prostrate condition of system. Finally, the same remark applies to this medicine as was made in regard to cold—dependent upon irritability, it is vain when irritability is lost. But it may be given hypodermically, and thus two of the objections are obviated. Especially may it be of great value to give them ergotine in sulphuric ether. Nevertheless I must believe that ergot is not so much needed in the fierceness of the fight as to assist in holding the citadel first won by other means.

*Quinine*.—Even in hemorrhages unassociated

with malarial fever, but which are periodical in recurrence, this agent is of the first importance. So, too, where there is no periodicity it is often useful.

*Opium*.—Its use in uterine hemorrhage dates at least as early as Hoffman, and it has been a great favorite with many prominent British practitioners. But opium is an agent for the after-treatment rather than for the time of the flooding. It relieves spasmodic uterine contraction ; it sustains an exhausted nervous system ; it secures rest. Collins gave it with a free hand, stating that he never saw any injurious effects from thirty to forty drops of the tincture administered every twenty to thirty minutes and continued until one hundred and fifty or two hundred had been given, while Barnes advises thirty or forty drops of Battley's solution once in two or three hours.

*Hot Baths*.—This treatment, suggested by Tannier, has been strongly advocated by Bailly, who includes secondary hemorrhage between the second day and one month after delivery. These baths are used only ten days or more after labor ; the temperature about 34° C., and the period of immersion varies from twenty minutes to half an hour. I am not sure that this method of treating secondary hemorrhage has been used in this country.

In conclusion, several other topics belonging to therapeutics of uterine hemorrhage might be presented, such as *position, transfusion*, etc., but I do not attempt an exhausted paper—a term that sometimes has a double application, application to the subject and to the hearers, and I shall be quite satisfied if by the valuable discussion which ensues it may be evident, adopting a comparison from Horace, that I was at least a whetstone.

#### MANAGEMENT OF THE SHOULDERS IN LABOR.

I have been led to write a short paper on the management of the shoulders in labor, for the reason that I discover that lacerations of the perineum very frequently occur after the safe delivery of the head. This accident has recently occurred to two of my friends in a single week. In both these cases the head had been safely delivered with the forceps. In one of them, indeed, I had myself assisted the gentleman in attendance in delivering the shoulder presenting anteriorly, and yet the perineum was torn to a considerable extent in the delivery of the remaining shoulder. This looks like faulty midwifery, yet we are told by all the authorities on the subject that such instances are of very common occurrence. Any suggestion, therefore, which tends to obviate this unpleasant accident must, it seems to me, have a practical importance.

I have never met with a case of ruptured perineum in my own practice, which embraces two thousand midwifery cases. I do not know

whether this is owing to good fortune or to the means which I invariably adopt in all cases which I am called on to attend. Of course I have met with slight lacerations of the fourchette, but not of sufficient seriousness to require surgical interference.

In the "Transactions of the Medical and Chirurgical Faculty" for 1877, there will be found an article of the writer on the management of the perineum during labor. In that article I mention the various means necessary to be employed to protect its integrity. I there state that the proper plan is, before the head actually commences to impinge on the soft parts, to pass the finger round the whole surface of the perineum, inside, during the pain, and attenuate the tissues by drawing them downwards and backwards. This kind of *massage*, so to speak, is of great service in preparing the perineum for the severe strain it is about to undergo. When the pains are of a violently forcible character it is necessary, of course, to guide the head and control its movements; but if the soft parts be properly prepared in the manner I have suggested, the perineum may be readily slipped under the chin, and the term of the labor thereby greatly shortened. I might now suggest, in addition, the proper management of the glottis and the extension of the left leg at this stage to produce relaxation of the sphincters. The abduction and flexion of the limbs are proper until the soft parts are completely stretched; then the extension of the left leg adds to the safety of the perineum by its relaxation and the increase in the degree of its inclination. These remarks apply more particularly to the management of the head, but they also have a bearing, as you will see hereafter, on the delivery of the shoulders. A great rest usually takes place after the delivery of the head, particularly in primiparæ. The young obstetrician at this stage awaits anxiously for a renewal of the pains and sees with horror the face of the child becoming livid. Fearful for its safety, he immediately commences to pull on the head forcibly downwards and backwards. A sudden and violent pain is excited by his efforts; the sphincters contract and the shoulders are suddenly expelled, tearing the perineum in their rapid course. I have seen this occur in the Rotunda Hospital, Dublin, and also several times in this city. It is not good practice at any time to draw upon the head. Among other *contretemps*, I have seen the head torn away from the body by futile efforts to deliver the shoulders in this manner. The proper plan after the delivery of the head is to rotate the shoulders in the reverse direction to that taken by the face, so as to bring them into the opposite oblique direction to that of the head. This rotation can be assisted by placing one hand upon the back of the neck and another upon the sternum as the shoulders are about to pass. The better plan, however, and the one I always adopt in cases of primiparæ, is to deliver each shoulder separately. After the

proper rotation of the shoulders, which should be done very gently, I pass two fingers up into the axilla of the arm presenting at the pubis, gently depressing the head in this movement. I then raise the head up towards the abdomen of the mother, and in a like manner deliver the remaining shoulder. The first shoulder should, if possible, be delivered before the pains re-commence, after the delivery of the head. If I do not succeed with two fingers I do not hesitate to pass the whole hand and draw down the arm. This is sometimes a little painful to the mother, but it invariably saves the perineum. The great frequency of rupture of the perineum by the shoulders is due to the fact that they are too often disregarded in the management of the labor. The head being delivered without injury to the soft parts, the accoucheur thinks all difficulty is over; but this is a very great error. The shoulders form abrupt stumpy projections which are very apt to cut the attenuated parts if not properly watched and controlled. I have not, in what I have written, given any attention to the treatment of those cases in which the great size of the shoulders arrests the delivery before the head is born, for the reason that this branch of the subject has been ably treated by a French gentleman, M. Jacquemier, in an excellent paper published some years ago.

I have spoken of the proper management of the glottis as a means of saving the perineum. Tyler Smith is the only author who dwells sufficiently on the importance of this matter. The more outcry the woman makes at the terminal stage of labor—that is when the head and shoulders are about to pass—the better. The extreme dilatation of the glottis adds to the safety of the perineum by the relaxation of the sphincters which it produces. The woman, therefore, should be encouraged to cry out at this crisis. Her very distress seems to be the means devised to save her from future injury.

Unfortunately, in our times, it seems that more pains are taken to look for injuries to the perineum than to guard against them. The whole system of midwifery formerly taught in the schools has been reversed by modern practice. The gynecologist appears to have taken the place in a great measure of the obstetrician. Women are now turned up and examined immediately after delivery in the search for lesions of the *genitalia*. I was greatly surprised at a meeting of the Obstetrical Section of the Medical and Chirurgical Faculty, last week, to discover that this practice is the unvarying rule of every member who was present. The old masters of midwifery would have looked with horror upon procedures of this character, and I beg leave, as one of their pupils, to protest earnestly against this unnecessary, if not indelicate, innovation.—*John Morris, M.D., in Maryland Medical Journal.*

## EPISTAXIS IN CHILDREN.

By F. FORCHHIEMER, M.D., Cincinnati, Ohio.

Epistaxis is a symptom occurring, with great frequency, in children past the age of ten years. Its causes are numerous and manifold; for convenience of study they may be divided into remote and local. The remote causes are to be sought for in the condition of the circulation and the blood. The local, in the condition of the mucous membrane and its blood-vessels. The circulation, especially its force, causes epistaxis, simply by producing rhexis of vessels; thus, in heart disease, by an increase of pressure either in the arterial or venous circulation; during attacks of whooping-cough, on account of impairment in return of the blood to the right side of the heart, the pressure in the veinules becomes so great that they are ruptured. In febrile diseases, measles, typhoid, either increase or pressure of diseased condition of the vessels may be the cause, in all probability the latter, for in some diseases, although accompanied by enormous fever, epistaxis is by no means common, so that, perhaps the poison circulating in the blood has already had time to affect the structure of the blood-vessels. All poisons of the blood can cause epistaxis, acting suddenly or slowly, and they do this not only by virtue of their affecting nutrition, but also on account of a change in the blood itself, causing the latter to change its physical and biological properties, and in this way producing transudation of the blood. But anæmia and plethora are accepted as causes of epistaxis. The former, in children, is by all means the more common cause: its action, as well as that of scurvy or purpura, must evidently be referred principally to the changes produced in nutrition, especially of the blood-vessels. Anæmia, again, in the majority of cases, is simply a symptom, and it is by no means uncommon for us to find children made anæmic by going to school, swallowing iron by the quantity, bleeding every day, becoming still more anæmic, but, the cause not being removed, going from bad to worse, and, finally, being compelled to cease school from weakness, perhaps sent into the country and being cured in a short time. And so the many causes of anæmia may produce epistaxis, this, in its turn, increasing the anæmia, and circulus vitiosus being established, the patient may suffer seriously until the true cause is discovered and removed. The local conditions producing epistaxis are very numerous; nasal catarrh, ulcers, neoplasms, wounds caused by picking at the nose are the most common. From this it will be seen that it becomes of utmost importance in cases of epistaxis to examine the cavity of the nose. In older children both the posterior nares can be examined carefully. In younger children, however, only the anterior nares can be looked into; but these can be seen with perfect satisfaction. For this purpose it is not necessary to be the possessor of any expensive instrument in the form of a rhinoscope, any ordinary ear speculum being

sufficient to make an adequate examination of the anterior nares. Indeed, with the exception of rare cases, this is sufficient, for in the anterior nares do we most commonly find the local cause of epistaxis. According to my experience, this is usually one or more ulcers, situated low down upon the septum. These ulcers may be caused by catarrhal processes, or they may be the result of a trauma. In either case they are slow to heal, and during their presence the patient has repeated attacks of epistaxis. Cases have occurred in my experience in which these ulcers are present, but epistaxis does not occur, this condition being due either to the fact that they do not involve any blood-vessels, or that they are so protected that an epistaxis cannot arise. But given a case in which both the ulcers and epistaxis are present, a single treatment of the ulcers usually does away with the epistaxis. When epistaxis is due to constant picking it becomes absolutely necessary to use both moral and physical restraint. It rarely becomes necessary to tie the hands of these little patients, but this measure should certainly be resorted to when the bleeding is excessive. The treatment of epistaxis is that of its causes. The general causes must be seen to; indeed it is most important to detect them, as without them no rational therapy of epistaxis can exist. It is my intention to refer briefly only to the treatment of nose-bleeding from local causes. Nasal catarrh is best treated in children by remedies that can be applied by the parents. Boracic acid in the form of a 2½ per cent. solution in water, or in the same strength mixed with vaseline, gives very acceptable results. This is to be applied to the anterior nares, and allowed to flow into the pharynx. Sulphate of zinc, in one-fifth per cent. solution in glycerine and water, applied in the same way may also be used to advantage. The greatest care should be taken in detecting ulcers, and when found it is necessary simply to touch them with the mitigated stick of nitrate of silver, and the bleeding stops instantly, in many cases never to return. In other cases repeated applications are necessary; even when there seems to be present a marked condition of anæmia, these ulcers must be treated, as frequently the ulcers are the cause of the anæmia, the link being the constant loss of blood from the nose.—*Cincinnati Lancet and Clinic.*

## ANGELS' WHISPERS.

The beautiful nursery conceit that the sweet smile of the slumbering infant is caused by the whisper of an angel into its ear is destroyed by the revelations of unemotional science. Dr. Charles Bell attributes the smile to reflex muscular action due to intestinal flatus, the rotation upwards of the eyeballs, and the tremulo us movement of the lips being due to a far different cause than a communication from the unseen world.—*Cincinnati Lancet and Clinic.*

## COUGH AND ITS LOCAL TREATMENT.

By LOUIS ELSBERG, M.D., Professor of Laryngology and Diseases of the Throat in the Medical Department of the University of New York.

Among the subjects of interest to every physician, cough certainly holds a prominent place. Since the introduction of the laryngoscope much positive information has been obtained as to its frequent seat, and sometimes simple cure. But this knowledge seems not to have reached as yet the profession at large. Without by any means exhausting the subject, I desire to call attention to a point or two.

We know cough to be a reflex action for the expulsion of foreign matters from the air-passages. Accumulation of matter, such as mucus, etc., or, in fact, irritation in different portions of the tract, may cause it. Its most frequent cause is irritation at the upper aperture of the larynx, especially its posterior portion: namely, the inter-arytenoid fold, and also the free edge of the epiglottis. Here both action and reaction are at work; an irritation of this locality, as, for instance, an erosion of the mucous membrane, is apt to produce cough; and cough from any other cause is apt to produce such an irritation. Each of these two factors, cough and this irritation, can produce the other; when both are present they make each other worse.

Irritation lower down in the respiratory passages, namely, at the posterior wall of the larynx and trachea, the bifurcation of the bronchi, and the mucous membrane of the bronchial tubes, can also produce cough, while it seems irritation of the parenchyma of the lung itself and of the pleuræ cannot. The fact is that usually the cough, accompanying pulmonary and pleural disease, comes from associated bronchial, tracheal or laryngeal complication. On the other hand, although it would not be true to say that there is no cough-producing spot above the larynx, yet even nasal or pharyngeal catarrh and elongated uvula frequently excite cough only by the irritation of the upper laryngeal aperture, by the descending secretion in the one case, and the relaxed extremity of the uvula in the other, either directly or indirectly. The remote causes, as in hysterical and nervous cough, ear cough, so-called stomach cough, etc., act by influencing the motor reflexes, sometimes by means of the independent sensory center (the existence of which clinical observation, as well as anatomical reasons, have led me to assume), often, I believe, with implication of the vaso-motor nerve.

At all events there can be no doubt that the great majority of all persons who cough primarily or else secondarily, an irritation at the upper aperture of the larynx, either its posterior or anterior portion, and local treatment of this irritation, sometimes of the simplest kind, relieves (sometimes cures) them.

Almost any physician worthy of the name may, with an expenditure of less than an hour's time, and not much more than a dollar in money for the

purchase of a laryngoscopic mirror, learn to inspect his own or another's larynx. He can, therefore, find no excuse for the omission, in a case of cough, to use the laryngoscope. If a good view of the aperture and interior of the larynx be obtained, the physician may recognize any structural lesion present, and should either himself or let some one else treat it. Sometimes conditions exist which no local treatment can reach, sometimes the condition may require measures that cannot be expected from a general practitioner; but, aside from any other affection, there will very frequently be seen erosion, fissure, or ulceration of the inter-arytenoid fold, or erosion of the epiglottis, which every physician ought to be able to relieve.

With the laryngeal mirror in the left hand, the patient holding his tongue out himself, the physician should, with his right hand, by means of a piece of soft sponge fastened in the sponge-holder, apply to the affected part a saturated solution of iodoform in sulphuric ether (one part of crystalized iodoform to four parts of ether dissolved by simple agitation, kept away from the light, and flavored with a little oil of wintergreen or musk). There should be no dropping from the sponge, therefore it had better be squeezed out before the throat is touched with it; and there should be no slobbering, therefore the physician ought to acquire some dexterity in practicing on a model before making an application to a patient. The use of the iodoform solution may be repeated every day or every other day for a week or more. Sometimes other applications may be needed in the proper treatment of the case, but the iodoform will, in almost every instance, contribute something to the relief of the patient.—*Chicago Medical Review.*

## ASPIRATION OF THE GALL BLADDER.

P. H. Kretschmar presented to the society a paper on dilatation of the gall bladder; its treatment by aspiration. The object of the paper was to call attention to the surgical treatment of dilatation of the gall bladder from whatever cause produced. In looking over the literature of the subject he found very little in the works of the leading authorities.

He considers the use of the aspirator in cases of enlarged and distended gall bladder as perfectly safe, and therefore an operation that may be resorted to as soon as the diagnosis is made out; or one that may be utilized for the purpose of completing a diagnosis.

He reports a case in which the patient was aspirated five times, and thirty-four and a half ounces of bile were removed within a month. At every operation the patient felt much relieved, and after the first operation the constitutional symptoms were much diminished in severity. Of course, this surgical interference did not take the place of, it only supplemented, the medical treatment of the case.—*Proceedings of Medical Society of County of Kings, Sept., '81.*

## THE TREATMENT OF ABORTIONS.

By GEO. T. HARRISON, M.A., M.D., Assistant Surgeon to the Women's Hospital in the State of New York.

The immediate consequence of an abortion may be such excessive and exhausting hemorrhage as to cause the speedy death of the patient. Septic infection also may follow rapidly upon an abortion and carry off its victim.

Our therapeutic endeavors should, therefore, be directed to a prevention of hemorrhage, or, at least, to its limitation within bounds consistent with safety to the patient—to the avoidance of septic infection and its consequence—and especially should it be an object of our earnest effort to secure perfect involution of the uterus.

The bleeding is the first symptom usually which demands our therapeutical intervention. What that shall be will depend on the result of our examination per vaginam, which should be made at once, the patient being in the dorsal position, with the knees flexed. If it should now be found that the os uteri is but slightly open and the cervical canal therefore not accessible to the exploring finger, the best thing to do is to apply a vaginal tampon. The tampon arrests the hemorrhage and stimulates uterine contraction, and fulfills the indication completely. To proceed at once to the use of dilatation, whether gradual by the tent or rapid and forcible by the several mechanical contrivances of late devised for this purpose, is unjustifiable in view of the unnecessary dangers to which the patient is thereby subjected from septic infection consequent upon the injury to the uterine tissues which that treatment may cause. For the tampon there is nothing superior to absorbent cotton, each piece being dipped in a solution of carbolic acid (two and a half per cent.) and well wrung out. It frequently happens after the tampon is removed in from six to twenty-four hours, that the ovum is found in the cervix or in the vagina. In the first case it is usually an easy matter to remove it by the finger. In the second, the scene of course is ended. It happens, however, now and then, that though the ovum has descended into the cervix partially or entirely, yet the external os remains undilated, and presents an insuperable obstacle to the passage of the finger. In these circumstances Schroeder advises the incision of the os and cervix on each side to a greater or less extent. The ovum is then readily extracted manually. The divided surfaces are immediately united, observing strict antiseptic precautions. I concur fully in the view of this distinguished author, that such procedure is better than forced dilatation.

A method of removing the ovum, applicable especially in the first three months of pregnancy, was suggested by Hœning. It consists in expressing the ovum out of the uterine cavity instead of extracting it. Two fingers of the one hand are introduced into the vagina and applied against the uterine body in the anterior or posterior fornix vaginae, according to the position of the uterus,

whether ante or retroverted, while the other hand, from the abdominal walls, presses the uterus against these fingers. The ovum is forced into the cervix and then slips immediately into the vagina. I cannot commend this procedure too highly. I have practiced it with great satisfaction.

If the physician, however, on reaching the bedside of the patient, ascertains that the membranes have ruptured and the liquor amnii has escaped, active interference is called for—the clear indication being to remove the uterine contents as speedily and completely as possible.

Without entering into any elaborate argument, it is sufficient to say that where portions of the ovum are retained in the uterine cavity, there is always menace of putrefactive decomposition and absorption of its products involving a long train of morbid sequences of hemorrhage; and especially is defective involution thereby a frequent result.

The measure which I would warmly commend, and which I have used for years with entire satisfaction, for the expulsion of the retained ovum, is the intra-uterine injection of hot water, made antiseptic by the addition of carbolic acid or salicylic acid. The patient lies on her back across the bed, with her hips near the edge, with a bedpan placed beneath her. The physician then takes a Davidson's syringe and attaches to its nozzle, by a piece of rubber tubing, a flexible male catheter. With the forefinger of one hand in the vagina, this can be readily guided into the os externum and thence into the uterine canal, taking care to expel all air in the first instance. It is important, of course, that the uterine canal should not embrace the catheter too closely, as there ought to be sufficient space for the free escape of the water pumped in. The first attempts should be exceedingly cautious, and the water must not be thrown in under too great a pressure. The hot water acts in two ways—partly mechanically and partly by stimulating the uterus to energetic contraction.

It is but right to state that this practice is condemned by one eminent authority, Dr. Carl Braun. The admonition of so eminent an authority is worthy to be well weighed. I believe his apprehensions, however, are groundless, if the canal is open, as it almost always is soon after the escape of the foetus (and these are the cases we now have in view), and if, moreover, we are careful in making the first injections. The hot water soon relaxes any constriction or tendency to spasm at the internal os, and its escape from the uterine cavity is thus facilitated. It is also important to introduce the index finger of one hand (the left by preference) into the vagina, when making the injection, and press back the posterior wall from the os externum to still further promote the free discharge of the water. This finger will also detect the presence of pieces driven into the cervix as far as the os externum. Withdrawing the catheter now and using bi-manual manipulation, the uterus can be depressed so as to allow the

finger in the vagina to pass into the cervical canal and remove its contents—the finger acting as a hook. The hot-water injections can then be again employed until other portions are either driven into the cervix or forced into the vagina. Even if all the portions of the ovum are not expelled now, the hot water arrests all tendency to hemorrhage, and in the course of the next twelve or twenty-four hours can again be called into play. After finishing the injection, a pledget of absorbent cotton wrung out of a 2½ per cent. solution of carbolic acid and saturated with glycerine, is placed against the os externum. If we have succeeded in cleaning the uterus of its contents, we need not use the injections the next day; but if there is any uncertainty they should be given. It is a matter of importance that no fluid should be left in the uterine cavity, as violent uterine colic might otherwise ensue; therefore, in withdrawing the injection tube (or catheter) the hand above the pubis should grasp the fungus through the abdominal walls and force out its contents.

If the membranes have ruptured some time before the physician is summoned, and the cervix has closed so as not to allow the passage of the finger, I would most earnestly advocate the use of chloroform or ether, as Dr. Fehling and others suggest. It is then easy, as a rule, to pass the finger through the internal os and attain to the uterine cavity; so that by means of the co-operation of the other hand—acting through the abdominal covering—in bringing the uterus within easy reach of this exploring finger, the retained parts may be readily removed, either partially or entirely. In the first case, the hot-water injections are invoked and speedily complete the expulsion of the uterine contents. Those who have never made use of it will be astonished at the relaxing power of the anæsthetic, for the finger gains admission through an internal os under its influence, where before it seemed rigidly closed. It need hardly be said that the facilities afforded for bimanual investigation are thereby greatly enhanced.

We have seen that one important indication of treatment in abortions is to secure perfect involution. In the use of intra-uterine injections of hot water we have a therapeutic measure at our command incomparably superior to any other in effecting this result. Since I have appreciated their power I have never had occasion to use ergot. It is certainly a matter for congratulation to be able to dispense with the use of so nauseous a drug, and one which, no matter how administered, is apt to cause disagreeable symptoms. I would therefore most earnestly deprecate the practice of those who find an exponent of their views in the French author Cordes, who will wait, even when the placenta has undergone putrefactive decomposition, for the uterus to expel its contents spontaneously, and rely upon the internal administration of ergot and quinine to stimulate uterine contractions. Under such treatment, I have seen a patient, the subject of a metrorrhagia, protracted

a year subsequent to the abortion—the uterus in a condition of sub-involution requiring a long course of treatment for its relief. In some cases, the physician does not see the patient who has aborted until a number of days have elapsed after the expulsion of the foetus, and the os-externum and cervical canal are completely closed. Under such circumstances, we must first dilate with tupelo or laminaria tents, first making them thoroughly antiseptic, and then proceed as before with the hot-water injections.

An important practical question is this: Suppose, in a case of retention of the ovum or its parts, high fever or septicæmia or perimetritis develop, shall we have recourse to active interference or not? Active interference is here, undoubtedly, the proper course to be pursued, and the one which I have invariably adopted with perfect satisfaction.

It is not necessary to insist upon the value of the use of the vaginal douche of hot water, repeated several times daily, and continued for at least two weeks after the abortion.—*Virginia Medical Monthly*.

#### OBSTETRIC APHORISMS.

By H. WEBSTER JONES, M.D., Chicago.

1. An intelligent confidence once thoroughly established between patient and physician does much to banish the terrors of the lying-in room.
2. It is possible to foresee and prevent the occurrence of the almost fatal form of eclampsia gravidarum.
3. Cleanliness is especially next to godliness in the case of the accoucheur. Its absence renders one liable to professional homicide.
4. The modern midwifery must not be meddling, but must be mediatorial in the sense of palliating suffering, expediting nature's processes by well-proven means, and removing scientifically all inexplicable, accidental or morbid states and conditions. Idleness is no longer an approved qualification for a degree of obstetrics.
5. The hand is the best uterine dilator.
6. The forceps should never be employed until the os uteri is dilated or dilatible, and then not unless the membranes have been ruptured and labor delayed unnaturally for at least an hour. Every practitioner should become skillful in their use, and they should never be left at home for fear of temptation.
7. Unnecessary and avoidable delays in labor are fruitful sources of gynecological practice. They promote inflammation and sepsis.
8. The patient's hopeful confidence and the physician's industrious attention, actually contribute to the physiological elements of labor. Anæsthetics here, are, to say the least, superfluous.
9. Bi-manual aid in effecting the deliverance of the placenta is not only proper but advisable.

Skillfully rendered, the cry of "uterine inversion" becomes no longer a bug-bear.

10. The continuous and intelligent counter-pressure over the fundus uteri during the child's exit, the delivery of the placenta, and the period of frequent oscillation, be that a shorter or a longer time, is a safeguard never to be neglected.

11. Pursuant to the same end, the application of the bandage and its continuance, as long as the uterine globe can be felt and embraced by it above the pubis, contributes not only to comfort, but to speedy involution. After the seventh day close pressure must be interdicted.

12. Puffiness of one ankle, with tenderness of the corresponding groin, and an abnormally quickened pulse, with or without copious sweating, noticed within the first ten days after labor, betoken the presence of phlebitis, and the possibility of embolism or thrombus, and resultant sudden death.

13. The duties of an obstetrician are not concluded until a careful examination, from six to eight weeks after parturition, proves the integrity of all the organs concerned.—*Michigan Medical News.*

#### OVARIAN IRRITATION AND PAIN, ASSOCIATED WITH CERVICAL INFLAMMATION.

A class of cases which may be approximately described by the foregoing heading, will be recognized by practitioners as exceedingly vexatious and unyielding to treatment, local or general. In response to some inquiries made to our correspondent, Dr. Herrick, of Grand Rapids, we have received the following suggestions:

"As for the cases you mention, I think all of us are more or less puzzled to always treat them properly. I, as well as you, often meet with *chronic ovaritis* complicated with cervical engorgement, and in addition to the treatment heretofore mentioned (see *July Gazette*), I pack the upper portion of the vagina with cotton saturated with an ointment, composed as follows:

℞. Vaseline..... ʒ iij  
Chloral hydr..... ʒ i  
Ol. erchthites..... ʒ ss  
Fl. ext. hamamelis.... ʒ iss

And to this I sometimes add—

Tinct. iodine..... ʒ ss

These should be thoroughly incorporated in a mortar.

This applied against the inflamed organ will often quiet the pain.

Besides this, I have sometimes thought I got the benefit from a blister over the outside of the ovary. Where the trouble arises from neurasthenia, bromide of ammonium is the sheet anchor. But, as a general rule, the ovarian irritation will subside with the cure of the uterine trouble."

Upon being asked what advantages were to be

had from the addition in this formulæ of the fire weed and witchhazel, the doctor says:

"Fire weed (*erchthites*) was suggested to my mind from its being used in uterine hemorrhage; it is supposed to act like ergot in one respect, i. e., by contracting the capillaries, but it does not possess the other power of ergot, that of producing contraction of the muscles of the uterus. Of course if it produces contraction of the capillaries, it will help expel the blood from them, and will consequently lessen congestion and inflammation. This at least was my theory; and in my hands it has been borne out in practice, for I have noticed that cases improved faster after the fire weed was added to the ointment. I always use the oil, as it can be more easily mixed with the vaseline. As for the witchhazel (*hamamelis*), I make no claim of priority in local application, for it has been used for some time in leucorrhœa, ulceration, etc., I believe. To the homœopathic lights belong the credit of discovery; they have used a very dilute form of *hamamelis* in all forms of uterine disease for a long time, both as a local application and internally in the form of a 800 or 3,000 potency, according to the sense of the person prescribing. Our profession commenced the use of the drug in the shape of the fl. ext. and tinct. within the past four or five years, but only as a local application; and that it has some influence over the inflamed uterus and vagina, is now pretty well established from the fact that it is used now more or less by almost all gynecologists. Just what its '*modus operandi*' is I do not know; our *materia medica* does not say anything about its effects over these parts."—*Obstetric Gazette.*

#### IODIFORM IN UTERINE AND CATARRHAL DISEASES.

Dr. Fowler, of Youngstown, Ohio, makes a pliable mass for iodoform by mixing it with isinglass and glycerine. The isinglass is reduced to a jelly with steam, and enough glycerine added to give it consistency and pliability. The proportions are about as follows:

℞ Iodoform..... ʒ i.  
Isinglass..... ʒ viii.  
Glycerine..... ʒ iv.

—*Medical Reporter.*

#### CHRONIC ECZEMA OF THE PALM.

The following lotion I have found very beneficial in allaying the intense irritation which so often accompanies this common skin disease. It consists of bicarbonate of soda, 2 drachms; bicarbonate of potash, 1 drachm; glycerine, 1½ drachms; tincture of opium, 2 drachms; water to 8 ounces. I was at first induced to use it in a case of eczematous irritation, in which every application I had used proved of no avail, on account of the marked relief from pain which the local use of the bicarbonate of soda frequently gives in severe burns. On

ly a few days ago in the case of a lady suffering from chronic eczema of the legs, accompanied with intense itching, I used it with the most beneficial and immediate result, the patient showing me some half-dozen prescriptions which she had used with little or no success. I consider the bicarbonate of soda lotion almost, if not quite, a specific for the relief of the intense burning irritation which often attends chronic eczema, more especially if the patient have a rheumatic tendency.—*Dr. J. W. H. Lush, British Medical Journal.*

## THE CANADA MEDICAL RECORD,

Monthly Journal of Medicine and Pharmacy.

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MONTREAL, MARCH, 1882.

### CORRECTION.

In our January number we published a case of Acute Tuberculosis by Dr. McConnell in which several printer's errors will be discovered, and which were overlooked in the correction of the proof. As the writer has called our attention to these mistakes we would request our readers to make the following alterations so that the article may read properly, and as the author intended it should.

In column 2, line 15, for "twisted" read "turgid"; in line 22, for "full note" read "dull note"; line 26, for "skin" read "spine." In column 3, line 45, for "disappearing" read "appearing." In column 4, line 1, for "extracted" read "retracted"; line 26, for "trachea cerebral" read "tache ecrebral."

### COLLEGE OF PHYSICIANS AND SURGEONS OF THE PROVINCE OF QUEBEC.

We direct attention to the advertisement to be found in this issue, giving the date of the meeting of the Preliminary Board and of the Board of Governors.

### THE LATE DR. KENNETH REID.

We deeply regret to learn, from the *New York Herald* of the 23rd February, of the death of our personal friend and old subscriber, Kenneth Reid, M.D., a native of Huntingdon, Chateauguay County, after a short illness of four days, and in the 42nd year of his age. Dr. Reid was the eldest son of Col. Reid (retired), formerly of the 78th Highlanders. Before adopting the profession of medicine the deceased held an appointment in the Montreal Post Office, for which he was nominated by Sir John Rose. In 1864 he graduated at the McGill University of Montreal. He then went to Edinburgh, where he passed the Royal College of Surgeons. In 1869 he came to New York, was appointed a deputy health officer at Quarantine, and served for two years under Dr. Swinburne. He retained his position during the whole of Dr. Carnochan's administration, and by his rarelingual ability, as well as by his medical skill, proved a most valuable official. After this he made a tour in the Holy Land, and returning again to New York, established himself in practice. Dr. Reid was connected with the Ophthalmic Hospital, and was a member of the Medical Society of the City and County of New York. His disposition was so amiable that it endeared him to all who knew him, and the ability he displayed in the practice of his profession had already given promise of a brilliant future had his life been spared.

### TONGA.

Parke, Davis & Co., of Detroit, Michigan, the well-known manufacturers of therapeutic remedies, have just scored a triumph upon behalf of legitimate Pharmacy. The circumstances are briefly these:

Tonga is a compound of barks prepared by the natives of the Fiji Islands, and has borne in that locality for years the reputation of being an effective remedy in the treatment of neuralgia. A quantity thereof was brought to London in the year 1879 by a Mr. Ryder, who placed the same in the hands of Allen & Hanburys, druggists, London, in order that it might be introduced properly to the medical profession. The first information relative thereto which was published to the public or to the medical profession appeared in the shape of an article in the *London Lancet*, March 6, 1880, and March 20, 1880, as a communication from the pens of Drs. Wm. Murrell and



Sidney Ringer. Following this article were others of a similar nature in the *Lancet*, and one in the London *Pharmaceutical Journal and Transactions*, April, 1880, from the pen of Dr. Holmes, on the "Botanical Origin of Tonga." Believing that Drs. Murrell and Ringer would never have investigated and published the result of their investigations of any drug without it was free from any contamination of a proprietary nature, Parke, Davis & Co. assumed that Tonga was common property. Acting on this assumption they dispatched a special messenger to the Fiji Islands, 7000 miles south-west of San Francisco. After a sojourn of six months he returned to Detroit in December, 1880, bringing with him a large supply of the drug. They at once put on the market a fluid extract of it, and advertised it extensively in the Medical Journals. Soon, however, they were notified by Ailen & Hanburys, of London, to discontinue the use of the word "Tonga," as it was a registered trade mark. This Parke, Davis & Co. declined to do, upon the ground that the name was that of a geographical locality, and therefore not patentable in the United States, and that the *only* name of an article, being the only specification by which the article itself is known or described, is the common property of all, and cannot be appropriated by any one individual to his sole and exclusive use. They, moreover, claim that the word "Tonga" is the name of a medicinal compound used by the natives of Peru. Not satisfied with this reply, the London firm, through their agents, Messrs. W. H. Schieffelin & Co., of New York, took out an action against Messrs. Parke, Davis & Co. to restrain using the word "Tonga." The case went to suit, but as soon as the defense proved by two reliable witnesses that the word "Tonga" had long been known and applied both to natural products and medicinal preparations, the complainants on their own motion obtained an order of court to dismiss bill of complaint, with costs to be defrayed by themselves. We congratulate Parke, Davis & Co. on their triumph; they deserve the thanks of the profession for the stand which they took upon behalf of legitimate pharmaceutical preparations, the manufacture of which should be open to all pharmacists.

#### W. R. WARNER & CO.'S PREPARATIONS.

We have more than once felt it to be our duty as well as our privilege to speak most favorably of the pharmaceutical preparations made by William

R. Warner & Co., of Philadelphia. Our acquaintance with this firm justify us in giving to them an extended notice. The value to the physician of the pharmaceutical products of a known standard and value cannot be over-estimated. We have so many tinctures, extracts, pills, granule, and preparations of every description that are either wanting in strength or care of preparation, that the results obtained are disappointing to the practitioner, that when we find a reliable house they deserve encouragement. Wm. R. Warner & Co. have expended large sums in procuring and testing the value of new remedial agents; they have one of the finest and best equipped laboratories in the country, and were the first to introduce many of the recent preparations which have become of so much value, not one of which has failed to be of use. We have been using their different pills with great success, and heartily recommend them to the profession. The manufacturer of chemicals and pharmaceuticals, in these days, must make the most strenuous efforts in order to be in the advance which is constantly being made in the discovery of new agents, new methods of preparation, and their introduction under special and careful instructions to practitioners.

#### PERSONAL.

Dr. Mewburn (M.D., McGill, 1881), late clinical assistant in the Montreal General Hospital, has accepted an appointment as House Surgeon to the Winnipeg, Man., General Hospital, and has left Montreal to assume his duties.

Dr. Wilkins, Professor of Physiology and Pathology in the Medical Faculty of Bishop's College, has been appointed Examiner in Physiology and Pathology at the University of Toronto for the ensuing term.

Dr. Davis (M.D., Bishop's College, 1875) is resident assistant Surgeon in the Colonial General Hospital, Georgetown, Demerara.

Dr. Eneas (M.D., Bishop's College, 1874), after spending his leave of absence in Montreal, has left to resume his duties at Wakenam British Guiana.

Dr. W. C. McGillis (M.D., Bishop's College, 1881) is now on en route to Bakna, Java, Netherlands, India, a Dutch possession, where he intends to locate and practice.