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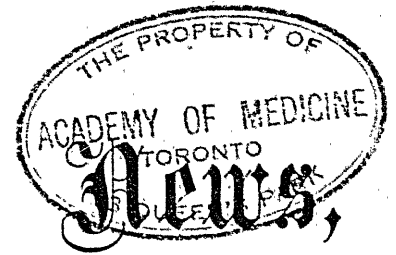
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A JOURNAL OF MEDICINE, SURGERY AND OBSTETRICS.

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No. 3.

## A RETROSPECT OF RECENT SURGERY.

BY JOHN STEWART, M. B., *Pictou, N. S.*

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In all its departments Surgery has, during the past year, made advances, in many cases as well grounded and beneficent as they are brilliant.

Surgical Anatomy has made more precise and lucid the rules which guide the surgeon in the arduous task of operating on the brain, and even in the commonplace sphere of amputation has furnished ingenious suggestions.

Surgical Pathology continues to engross the attention of many of the ablest minds, and has been studied with remarkable success, notably in the investigation of tubercular conditions and in applying to the problems of Surgery the potent influence of the Germ Theory of Disease.

Operative Surgery has acquired various new procedures, and has advanced to the assistance of Medicine in directions once undreamed of.

Finally, as a concomitant and result of all this activity, Surgical Literature has been enriched by many contributions of great interest and value. We propose to glance briefly at some of the more recent phases of Surgery and glean indications for our own guidance in following the triumphal progress of our Art.

### THE SURGERY OF THE BRAIN.

For daring, brilliancy, and success, the advances in this direction have been unsurpassed in the history of operative surgery. The cases reported by Mr. Macewen,\* of the Glasgow Royal Infirmary, at the recent meeting of the British Medical Association came as a dazzling surprise even on those who have given some attention to cerebral surgery, and his paper has been characterized by high authority as "in many respects the most remarkable contribution to surgical literature which the present day has produced." In his statistical *resume* he has been able to say: "Of twenty-one cerebral cases, (exclusive of fracture of the skull with brain lesions or other immediate effects of injury,) in which operations have been performed by me, there have been three deaths and eighteen recoveries. Of those who died, all were *in extremis* when operated on. Two were for abscess of the brain, in one of which the pus had

already burst into the lateral ventricles; in the other suppurative thrombosis of the lateral sinus had previously led to pyæmia and septic pneumonia. The third case was one in which there existed, besides a large subdural cyst over the one hemisphere, extensive softening at the seat of cerebral contusion on the opposite hemisphere, accompanied by œdema of the brain. Of the eighteen who recovered, sixteen are still alive in good health, and most are at work, leaving two who have since died, one eight years after the operation, from Bright's disease, she in the interval being quite well and able to work; the other forty-seven days after the operation, after the abscess was perfectly healed, from an acute attack of tubercular enteritis."

These statistics, be it noted, are exclusive of ordinary surgical cases, such as fracture and its immediate results. His array of cases unmistakably gives Macewen the first place among those surgeons who have distinguished themselves by their operations on the brain. Among the more interesting cases operated on by others during the last two years are those for cerebral tumour by Horsley and Godlee, of London, and Wier, of New York; for cerebral abscess by Caird of Edinburgh, Stokes of Dublin, and Horsley and Barker of London; and one by Thornley Stoker of Dublin for subcranial hemorrhage without fracture.

The issue of these attempts to relieve disease of the brain, or to obviate the results of injury to it, must rest largely, mainly indeed, on the accuracy with which the exact seat of the lesion can be localized, and in this direction the well-known labours of Ferrier have been ably supplemented by the experiments of Horsley; but very much remains to be done. In the case, for instance, of a tumour, not only should we know to what part of the cortex we should direct our attack but we should know the depth at which the growth lies, and have some idea of its extent. It would appear that cases of abscess are the most encouraging. Here the etiology is of great importance, for example, whether traumatic, or due to otitis, and the treatment is the simplest. In cases of tumour the difficulties of localization are usually greater, and are complicated by uncertainty as to the nature of the tumour and the feasibility of its removal. In the operative treatment of epilepsy the difficulties are also great. In the present state of knowledge it is perhaps unwarrantable to operate except in simple traumatic, Jacksonian epilepsy, and it is scarcely necessary to remark that particular care should be taken to learn the exact seat of the earliest attacks of spasm.

\* *British Medical Journal*, 1888, II., p. 302.



In a lecture reported in the *Lancet*†, Hare, now Professor of Surgery in Owens' College, Manchester, gives concise rules for mapping out the fissure of Rolando along which most of the motor centres are localized. He measures the total distance from the glabella, or space between the eyebrows, to the occipital protuberance. Measuring on this line from before backward, a segment equal to 55.7 of the entire distance gives a point which marks the upper end of the fissure. From this point downwards and forwards, at an angle of 67° to the sagittal line and extending for 3½ inches a line may be traced on the scalp corresponding to the direction and extent of the fissure of Rolando. Professor Hare points out that in most instances the upper end of the fissure may be determined by a point half an inch behind the centre of the first mentioned line.

As to the details of the operation itself we are indebted more to the published writings of Victor Horsley than to any other source.‡ He discards the old-fashioned crucial incision for a large flap, which, of course, must be formed carefully with reference to arterial distribution. He adopts Macewen's plan of replacing the trephine "buttons" and any other portions of bone removed. His experience is against the use of drainage for it appears that the arachnoid like the peritoneum has great absorptive powers. He invariably uses chloroform as the anæsthetic, and expresses the opinion that when the dura mater has been opened an unusually small quantity of chloroform suffices to keep up anæsthesia. He gives a hypodermic injection of morphine before administering the chloroform, first, because a smaller quantity of chloroform is required, and second, on account of the action of morphine in producing anæmia of the brain, an action first observed by himself and Ferrier in experiments on monkeys, and which he considers to be of some importance in dealing with a tissue in which the control of hæmorrhage is unusually difficult.

#### ABDOMINAL SURGERY.

The peritoneum has been in recent years the happy hunting ground of the surgeon. Long a *terra incognita* regarded with timorous and mistrustful eye by the surgeon who for any reason may have had to venture into its labyrinthine expanse, this dark continent has now been thoroughly explored, and we are familiar with its natural history. Need it be said that much of the mystery which once enshrouded this region has been swept away, and that many of the views once held regarding it have proved visionary.

Nothing has been more startling in this revolution of surgical opinion than the demonstration of the remarkable power of self-protection against septic influences possessed by the peritoneum. It was at one time considered one of the most noteworthy achievements of antiseptic surgery that, under it, operations involving the peritoneum healed so well. In his

lectures on Suppuration and Septic Diseases,§ by far the most valuable contribution of the year to this department of knowledge, Watson Cheyne has shown that the peritoneum possesses in a marked degree that power upon which Lister in his clinical lectures is wont to lay so much stress, the power of the healthy living tissues to destroy septic organisms, provided these are not in excess.

It is the appreciation of this fact which has led surgeons to deal so boldly with wounds of the intestine and abdominal viscera. Compare the practice in the day of that Master of Surgery, Syme, or even the practice of ten years ago, as for example in the pages of Erichsen, (7th edition,) with the procedure in any first-class Hospital to-day. Syme said, "in respect to the treatment of wounded intestine, it is evident, that, unless the injured part presents itself to view no local treatment can be employed to remedy the injury."\* The surgeon of to-day says, if the injured part do not present itself to view it must be brought into view, and dealt with as required. In the face of recent results the surgeon who allows a patient with a penetrating stab or bullet wound of the abdomen or a ruptured bladder, to die, without making an effort to get at the visceral lesion by aid of abdominal section is guilty of a fatal faint heartedness. Apart from the danger of fecal or urinary extravasation is the risk of hæmorrhage and a wound in an abdominal viscus is no exception to the golden rule of surgery, "tie the bleeding point."

During the past year there have been many reports of cases treated on these lines with perfect success; indeed, in no department of surgery has there been greater activity or more thoroughly justifiable work.

H. C. Dalton, of St. Louis records a case† in which bullet wounds of the stomach and liver were sutured, the patient making an excellent and speedy recovery, and appends a valuable table of statistics embodying the results of 69 reported cases. Five-sixths of these have been reported since 1886, and 19 since the date of Sir Wm. MacCormac's lecture in May, 1887.‡ These statistics give a recovery in nearly 40 *per cent.* of the patients operated upon, while under the old expectant treatment recovery in such cases did not occur in 8 *per cent.*

While the indications for operative interference in penetrating wounds of the abdomen are unmistakeable, they are scarcely less so in acute intestinal obstruction. In fact, the cardinal rule for herniotomy, "when in doubt, operate" may be applied to those cases in which the hernia is concealed, or in which there is acute intestinal obstruction due to bands, intussusception, mesenteric fenestræ, etc. In a paper read before the Brooklyn Pathological Society,|| Rockwell gives a table of statistics of laparotomy in acute intestinal obstruction, the number of cases being, curiously enough, the same as in Dalton's statis-

§ *British Medical Journal*, 1888, Vol. I., pp. 404, 452, 524, et seq.

\* *Prin. of Surgery*, 3rd Edition, p. 302.

† *Annals of Surgery*, Vol. II, p. 81.

‡ *British Medical Journal*, 1887, I, 975, 1001.

|| *Annals of Surgery*, Vol. I., p. 81.

† *Lancet*, 1888, I., 407.

‡ See for example *British Medical Journal*, '86, II., 670.

tics for laparotomy in traumatic lesions, viz. 69. Of these 39 recovered, or 53 *per cent.* Previous to 1873 the rate of recovery was not more than 27 *per cent.* Rockwell points out the important fact that of the 32 fatal cases, 20 were operated on after the third day, or were *in extremis* at the time of operation. He considers that if the operation had been done early the percentage of recovery might have been 83. Doubtless the diagnosis in many of these perplexing cases is difficult, or simply impossible, yet delay is dangerous, and Treves, whose work in this department is conspicuously good, advises operation in the first forty-eight, or, if possible, twenty-four hours after the development of marked symptoms. The desideratum now is a series of successful *early* operations, so that the profession may acquire confidence in surgical treatment. Among others a typical case has been recorded by Mr. Penny, assistant surgeon to King's College Hospital, London,|| in which he operated for acute intestinal obstruction in a child four years of age on the second day of the disease, and found that "ten inches of the lower part of the ileum had passed through a hole in its own mesentery and subsequently become twisted on itself." The symptoms ceased immediately and recovery was uninterrupted,

Recent pathology has shown that the appendix caeci is usually the seat of trouble in perityphlitis. Treves recommends laparotomy in these cases and advises removal of the appendix especially in cases where the disease has been recurrent. Successful instances of the operation have been recorded.

Abdominal section has also proved a success in cases of suppurative peritonitis and even tubercular conditions have been benefited by this procedure. Dr. John Homans, of Boston, reports a case which parallels the historic case of Spencer Wells. In Homans' patient the peritoneal surface was distinctly tubercular, when exposed. Three years after the patient was fat and strong and able to do her housework.

#### THE SURGERY OF THE JOINTS.

Ever since, in 1865, the researches of Villemin demonstrated the special infectivity of tuberculous matter there have been pathologists who doubted the ordinarily received opinion that tubercle and scrofula were two separate diseases. And histological research as well as clinical study gradually added proof to proof for the view of the minority when Koch announced, in 1882, his discovery of the *Bacillus tuberculosis*, and its presence in both tubercle and scrofula. And careful experiments have proved the causal relation of this microbe to both tubercle and scrofula, for, from material taken indiscriminately from a tuberculous focus in a lung, from a scrofulous joint, or from a caseating lymphatic gland, the *B. tuberculosis* can be cultivated in nutrient media outside the body, isolated from other organisms, and inoculated into healthy tissues, producing in every

case a true tuberculosis, "with as great certainty as deep sleep is produced by the hypodermic injection of morphine."§

Now while it is matter of common observation that scrofulous disease of a joint may remain quiescent for an indefinite period, it is equally certain that if this quiescence be disturbed from any cause, and liquefaction of caseating foci, with perhaps suppuration take place, there is disseminated disease, the glands and the viscera become affected.

With the light thrown on this subject by the discovery of Koch and the experiments and researches of others, as Baumgarten and Watson Cheyne we see that this general affection is an infection. The secondary disease in the lung, the intestine, or the brain, is not the result of some occult and intangible process, but it is an evident inoculation of a specific organism.

It is then of the utmost importance that scrofulous joints should be carefully watched, every care taken to preserve them from injury or irritation which might rouse the latent disease into virulent activity, and if this cannot be prevented, early exploration of the joint cavity and removal of the diseased parts must be undertaken. Now, it is the vascular parts of the joint, synovial membrane and the cancellous tissue of the articular ends of the bones, that the disease attacks first. The indications, therefore, are for the removal of these structures. In the operation of excision, the synovial membrane, except that portion removed with the articular surfaces of bone, was not interfered with, bone was removed whether diseased or not, and scrofulous areas sometimes left. This operation, in cases of disease, is now giving place to a modified procedure, in which the joint is laid freely open, the diseased synovial membrane dissected away entirely if need be, and scrofulous areas in the bones gouged or scraped out. In the case of the knee-joint, the crucial ligaments are left intact, and if the patella has been reflected by division of its ligament, this can be sutured. Antiseptic precautions are of course observed, and as no inflammatory reaction occurs in the joint its mobility is not seriously impaired.

This modified excision is known as Arthroctomy, and has been largely practised on the Continent and by some of the younger surgeons in England, notably by Wright of Manchester, and by Barker of London, whose three lectures¶ on the treatment of tubercular joint disease, at the Royal College of Surgeons, in June last, are the best available authority on the subject, in the English language.

But it was long ago demonstrated by Lister that simple incision of a diseased joint, with drainage, (no injection of any substance being made into the joint,) is sufficient, in many instances, to check the advance of scrofulous disease, thus paralleling in a synovial membrane the results already alluded to as sometimes occurring in a serous membrane, the peritoneum.

§ Barker. *Lancet*, 1883, I, 1203.

¶ *British Medical Journal*, 1883, I, pp. 1202, 1259, 1322.

|| *Lancet*, 1883, Vol. II., p. 10.

## AMPUTATIONS.

Under this head we notice the directions given by M. Paul Berger for amputation of the arm in contiguity with the trunk. He advises exsection of a portion of the clavicle, by which ready access is had to the great vessels, round which double ligatures are placed, the arm being elevated before ligature of the vein. In this way the operator has much better control over hemorrhage, and there is also no danger of air being sucked into the subclavian vein.

C. W. Cathcart, of Edinburgh,\* from a study of the mechanism of locomotion, aided by instantaneous photography, has defended the partial amputations of the foot from the charges of certain surgical mechanicians who hold that Hey's and Chopart's amputations are not a success, and that if more than the toes must be removed, the whole foot should go.

## ERASION OF CARBUNCLE.

Carbuncles and boils are local infective processes and are determined by special micro-organisms. The researches of Rosenbach,† Garre,‡ and Watson Cheyne, are conclusive on this point. It has therefore been proposed to treat carbuncles by scraping away as much as possible with the sharp spoon and applying antiseptic dressings. This treatment has proved very satisfactory and has the merit of being expeditious.

## OPERATIONS DISCOURAGED.

The results of pylorotomy, and removal of portions of the stomach for malignant disease, are not encouraging.

The tapping of ovarian cysts, continues to be discountenanced by all ovariologists. An abdominal section properly performed is not so dangerous as the operation of tapping. Trachelorrhaphy would appear to have been pushed to its limits and performed with indiscriminate zeal. At all events its votaries have to reckon with the trenchant criticism of Noeggerath|| who denies, point blank, its *raison d'être*.

## WOUND TREATMENT.

It is doubtful if any surgeon of repute, operating at the present day, does not use some method of antiseptis. Whatever method be employed, there is no denying the fact that it is to the genius, the practical skill, and the perseverance of Lister that we owe Antiseptic Surgery. As has been well remarked in the *Lancet*, "another years experience has only deepened the faith of surgeons in LISTER'S great discovery, and the voice of those who once set themselves in opposition to this 'new thing' is now silent, or only heard in feeble protestations that their life-long faith and practice have been in substance, if not in form 'antiseptic.'"

And if the development of Antiseptic Surgery has been the most glorious chapter in the history of our art, the opposition with which it has met, has been

one of the saddest and most humiliating features. The blind prejudice, the serene capability for misrepresentation, the apathetic complacency in traditional methods which so long withstood the Apostle of Antiseptis, are almost inexplicable, explicable only by the fact that Darkness hates Light. And the darkness still hangs over remote and unhappy regions where Septic Surgery nurses its brood, Erysipelas, Pyaemia, Suppurative Fever, and comforts itself in the midst of its unmanageable offspring by the reflection that "the spray is going out of fashion." Perhaps it is: the spray and carbolic acid treatment may have served their day. There are more convenient methods now; and yet some of the most brilliant and successful surgeons continue to use the old system. Horsley, who has had such signal success in Cerebral Surgery uses the spray, Treves uses it in operations on joints, and Fischer of Breslau, in his recent great work on Surgery, states that he uses the "old fashioned Listerian carbolic dressings."

The first requisite to success in practising aseptic surgery is a thorough understanding of, and belief in, the Germ Theory of wound infection. The surgeon who has assimilated this doctrine and who has provided himself with any of the numerous, convenient and cheap surgical dressings now to be had, will not be at a loss for antiseptic methods.

## INJURIES OF THE EYE, WITH CASES FROM PRACTICE.

BY STEPHEN DODGE, M. D., HALIFAX.

THE following cases illustrate various forms of injury to which the anterior part of the eyeball is subject. They are of interest from the fact that the natural course of the diseased action arising from such injuries usually ends in more or less loss of sight; and in many cases, after much suffering, in destruction of the eyeball. Some of the cases are relatively infrequent, as the presence of foreign bodies in the Iris; others again are much more frequently met with, such as injuries and wounds of the cornea and lens. Corneal wounds, when made by a sharp cutting instrument, are not usually very serious, unless they are extensive. When the Iris becomes adherent to their borders they may by and by lead to inflammation of the deeper tissues and injury to sight. When the Iris becomes imprisoned between the lips of the wound, and is allowed to become involved in the cicatrix, the progress of the case is usually tedious. Sight is almost invariably impaired from the primary disease, and recurrent inflammations are much more likely to occur than in the preceding variety, when the Iris is simply adherent.

But the Cornea more frequently becomes injured from some substance other than a sharp cutting instrument. The corneal tissue may be traversed by a rough angular substance, leaving a wound irregular in outline, so that its edges cannot apply themselves

\* *Edinburgh Medical Journal*, March, 1888, p. 777.

† *Microparasites on Disease*. Trans. by Cheyne. New. Syd. Soc.

‡ *Ibidem*.

|| See review in *Lancet*, 1888, I, 231.

regularly, thereby causing an unevenness of surface over which the lids are constantly rubbing. Under these circumstances a state of irritation is produced in the corneal tissue which is apt to extend to the ciliary region, causing a tedious recovery. Even a slight abrasion of the cornea from any injury may give rise to diseased action out of all proportion to the amount of tissue destruction; showing that the very concussion of the eyeball is an important element in such injuries. What aggravates these cases of corneal disease still further, and adds to their importance, is the frequency with which the lens is involved in corneal injuries. Such cases often constitute some of the most serious difficulties met with in eye diseases, and give rise to much anxiety.

*Case 1.—Foreign body in Iris.* Alfred H—, a stone cutter by occupation, consulted me in May, 1880. While engaged at his work a piece of steel penetrated the cornea and lodged in the Iris of his left eye. Its bright metallic lustre was readily seen to the left of the pupil, near its border, and in the horizontal diameter. I advised its removal at once, to which he readily consented. I gave him Ether and then introduced an Iridectomy knife at the outer corneal border just as in the ordinary operation for Iridectomy. I was very careful to let the aqueous humour drain away slowly, so as not to disturb the position of the Iris, but allow it to remain spread out. I then with the Iridectomy forceps grasped the portion of Iris, near the pupil, which contained the piece of steel, drew it out and with scissors cut it off, leaving the pupil not much interfered with, except a little elongated outwards.

His sight was nearly or quite as good afterwards as before the injury. He has now removed to the United States, but his brother told me about two years ago that his eye has never troubled him since, and that his sight is good.

*Case 2.—Foreign body in Iris.* Philip W—, Machinist. Consulted me Nov., 1884. Found a piece of steel in the right eye, embedded in the Iris at its upper and inner part, rather nearer to the ciliary border than to the pupil. The accident had occurred only half an hour before. I advised its immediate removal, and made an appointment with him to have the operation performed in two hours time that I might meanwhile get some cocaine which I had ordered and had just arrived at the custom's office. I considered the case a very suitable one for testing the properties of that drug which had just been introduced on this side of the Atlantic, and I had been enabled to procure a small quantity of the drug through a medical friend in New York. After he went home, his wife, who expected to be confined in a few days, persuaded him, as he was not then suffering much pain, to defer the operation. I did not see him again for two weeks. His eye was then very much inflamed and the metal was also concealed by plastic exudation which covered it and also partially blocked the pupil. Extensive synechiae existed at the pupillary border. He had severe pain so that he could not sleep at

night. In short he had Iritis. What was at first a very desirable case for an operation, was now the very opposite, and I frankly told him so, and expressed surprise at his behaviour. Atropine failed to exert any influence upon the size of the pupil and the sight was very much impaired. There was no other alternative but to remove the piece of steel notwithstanding the unfavourable conditions. It was even difficult to locate its present site and I was partly dependent upon my memory. I used the cocaine not because I considered it was a proper case for it; but as an aid to the chloroform which was administered by Dr. Lindsay, who also assisted me at the operation. The cloudiness of the cornea at the site of the original wound, to the border of which the Iris was now attached, complicated matters very much. My object was while introducing the knife at the corneal border, to guide its point so as to free the attached Iris. Having succeeded in this I then, after some trouble, managed to grasp the piece of steel and finally accomplished its removal. I was surprised at the firmness of the newly organized material which held it down. This was the main obstacle to its removal, as the steel when first seen was lying partly on the surface of the Iris. It was a thin, flat piece, about one eighth of an inch square. If it had been very small its removal would have been more difficult. The subsequent healing was much more satisfactory than I had expected. In about two weeks the inflammation had almost subsided; though some ciliary injection remained for some time longer. The sight was very much impaired, as already stated, owing to the organized material in the pupillary space. I saw him about a year ago and found the eye strong, not abnormally sensitive in any way, tension normal, and with but little evidence of the original trouble, except a small corneal opacity. After the performance of an ordinary Iridectomy for an artificial pupil he has a prospect for very fair sight.

*Case 3.—Injury of cornea from gunpowder.* John McP—, miner. Consulted me in April, 1878. Left eye totally destroyed. Right cornea so injured that very little clear corneal tissue was left, except at the extreme upper border. The injury had occurred six weeks before. Inflammation of the cornea existed and intense photophobia. He remained under treatment for three weeks. The inflammation disappeared as well as the dread of light. The sight which at first was reduced to perception of light, improved. I then advised him to go home, so that the eye would become stronger and bear the operation for Iridectomy without the danger of lighting up fresh inflammation. During the latter part of June he returned and I operated without any difficulty; but as the clear portion of cornea was so much covered by the upper lid, he did not receive as much benefit from the operation as I had hoped. Having tried the effect of raising his upper lid and found how much improvement followed, especially when a prism with its base downwards was used, I determined upon making section of the superior Rectus tendon to allow the

eyeball to drop down somewhat. I accordingly performed the operation with manifest advantage, as he was able afterwards to read slowly, fair sized type, by bringing the book quite near, and when I caused him to look through a pin hole in a cardboard. I was obliged to use the latter device to counteract the extreme divergence of the rays produced by the proximity of the type to the eye. Some time after he went home he wrote me a letter. The fact that he was able to write at all, and by looking through a small hole in a cent, so interested me that I have kept his letter as one of the pleasing reminiscences of practice.

*Case 4.—Injury of cornea from gunpowder with cataract.* Jenkins P—, miner, living at Montague, Halifax Co. Consulted me April, 1880. Right eye totally destroyed. Left had the appearance as if an Iridectomy had been performed on the nasal side. The Iris was clean gone in this direction. Some years before he had received the injury, but the cataract was a subsequent development. From the position of the wound which the eye had received I feared the vitreous was not of its normal consistency. I advised him to have the needle operation performed rather than extraction. Although the former mode of dealing with the cataract was more tedious than extraction, yet I feared the latter was attended with more risk. With one eye gone and the other more or less damaged, the chances pro and con with regard to the mode of operative procedure required to be carefully examined. I explained to him what number of operations would be necessary, as I determined to avoid too great swelling of the lens substance from lacerating the capsule too freely. Altogether it required five operations, after none of which did troublesome reaction follow, as he was always able to return home after a week. They were repeated more frequently than is usually considered advisable; but as nothing untoward occurred each time, and as he was anxious to get at work as soon as possible, having a wife and seven children dependent upon him, I was tempted to adopt the course I did. The cataract fully disappeared, his sight for the distance was 2/7, and he was able to read No. 4 Jaeger, which is finer than ordinary newspaper type.

*Case 6.—Wound of cornea extending into the sclerotic.* Wm. Q—, aged 11 yrs., Halifax. Consulted me Dec., 1880. When at school was struck by another boy with a sharp piece of slate, making a wound in the left eye, at the upper and outer point of the cornea, extending across the ciliary region into the sclerotic. The wound was gaping somewhat, and the Iris presented between its lips, and in the posterior part, the choroid could be seen. The prolapsed Iris was easily replaced. I then put one stitch through the upper layers of scleral tissue, near the sclero corneal junction and further backwards another through the conjunctiva alone. Healing took place very kindly in a few days. The pupil was slightly elongated outwards and upwards owing to the attachment of the Iris to the posterior lips of the wound.

In the *Boston Medical and Surgical Journal*, Folio 73, Dr. Pomeroy, of New York, reports a case almost identical where he placed a suture in the sclerotic. His appears to be the first recorded case in Ophthalmic literature. From having heard the case described afterwards by Dr. Pomeroy himself in which he spoke of his anxiety as to the result and its complete success, I was induced to try the same method. This case of Dr. P.'s was copied into the *Ophthalmic Review*, a British periodical, published at that time. One of its editors, Mr. Windsor, afterwards collected a number of cases and published them in the *Manchester Medical and Surgical Reports* for 1871. Since then Dr. Pooley, of New York, has published another case in the *Transactions of the American Ophthalmological Society*.

*Case 7.—Wound of cornea with traumatic cataract.* Wm. R—, car repairer. Consulted me on Jan. 31st, 1877. On Jan. 15th his left eye was injured by a piece of iron which struck the cornea producing a wound about half an inch long running in an oblique direction from the supero-temporal region, downwards to the right. The lens was wounded at the same time. Had suffered a good deal of pain both night and day. Iris adherent to the wound at the pupillary border below. Lens very much swollen and pressed upon the Iris. Marked circum-corneal redness. Just able to discern light. Ordered a 4 gr. solution of atropine, which was kept up for 4 days. As the adhesions failed to yield and the swollen lens was causing increased pain, I re-opened a portion of the wound corresponding to the lower border of pupil and removed the lens with a curette. Atropia was applied freely to the eye, morphia was given at night, hot applications occasionally and a bandage. Very little re-action followed the operation. The pain disappeared and on the third day the wound was again closed. On March 10th found ciliary injection still present, and tension of globe slightly increased, with a little pain. Capsular opacity covered the whole pupillary space. Anterior synechia existed at the lower part of the original wound, and in the upper part there was post. synechia. I introduced an Iridectomy knife at the sclero-corneal junction above, passed it downwards well across the pupillary space and then dipped the point of the knife backwards so as to penetrate the membrane. A good opening was thus made which not only gave him good sight, but reduced the tension, by relieving the ciliary irritation. No trouble arose from the operation. On April 7th read No. 4 Jaeger, finer than ordinary type, with a 2½ glass, and his sight still remains good.

TRY the following prescription to abort an attack of acute bronchitis. Prof. H. C. Wood says that it is worth \$5000 to every medical student :

R	Potassii citratis, . . . . .	ʒij
	Syrupi ipecacuanhæ . . . . .	fʒij
	Succus limonis . . . . .	fʒij
	Aquæ . . . . .	ʒiij
M.	S.—Two teaspoonfuls every two hours.	

## A LARGE BILIARY CALCULUS.

ON the 3rd Nov., 1888, I was summoned to attend Mrs. M. B. a tall spare woman, age 62, the mother of eleven adult children. The patient had suffered much through life from constipation and "bilious attacks," the latter being usually relieved after the lapse of from twenty-four to forty-eight hours by the occurrence of copious bilious vomiting. She had at various times, and for many years, suffered from pain in the right hypochondrium, sometimes dull and aching, at other times sharp and severe. Previous to my offering any opinion as to the nature of her ailment she said that she had for some time felt a large, "hard lump" in the same locality and that she could feel it with her hand from the outside.

The bowels had latterly inclined to be costive and had not moved at all for the last three or four days. The present attack had commenced about that time ago, with severe abdominal pain nausea and general feverishness, after which free bilious vomiting set in without any mitigation of the other symptoms ensuing. Mustard poultices and hot fomentations applied to the abdomen had given no relief. Patient was in a high state of febrile excitement, pulse 104, full and strong, and slight delirium occurring at intervals. The abdomen was tense and somewhat tympanitic and very painful but the pain was not localized or increased upon pressure.

Diagnosing the case as one of intestinal obstruction, I treated it with warm poultices to the abdomen, a simple warm enema daily, either of starch infusion or of soapsuds with olive oil; and an occasional sedative dose of either opium or belladonna to allay pain and procure sleep. Small pieces of ice were sucked to alleviate the thirst which was intense, and the only nourishment allowed was in a fluid form, (beef tea, milk, peptonoids, &c.) and in small quantities, never more than f. ʒss. or f. ʒj. at a time. The febrile excitement soon subsided, but the bilious and occasionally foeculent vomiting continued free in quantity and recurring at intervals of not less than three or four, or more than seven or eight hours until the 13th inst, when the enema brought away a concretion of about the size and not unlike the shape of an old fashioned ounce musket ball. The pain and nausea then abated and the enemata and poultices were discontinued. On the 17th the patient was relieved without much difficulty of a biliary calculus, roughly cylindrical in shape, with one bluntly rounded and one fractured end, from which latter end the fragment passed on the 13th inst. had evidently been broken off. The second and larger fragment measured 1½ inches in length and ¾ of an inch in diameter and weighed 137 gr. (or ʒii., gr. xvii.) The fragment first passed having unfortunately cracked and fallen to pieces in drying, I am unable to state its weight or give its dimensions otherwise than as above.

After the passage of the second calculus, all bad symptoms disappeared, and in two days time the patient was sitting up and in excellent health.

L. C. ALLISON, *St. John.*

A PAINFUL FIBROMA AT END OF RING FINGER,  
14 YEARS STANDING.

MRS. W—, age 27, mother of three children, all living and healthy. Family history very good. Previous history, was quite well and strong through infancy and childhood. At 13 years of age began to have slight twinges of pain in right ring finger at about the middle of the third phalanx on its ulnar side. The pain was described as being like a jumping toothache. It was felt only during excitement, exposure to cold, or sudden changes of temperature, and would disappear on applying heat. There was no tenderness on pressure. One year after the onset of pain in finger patient menstruated. This was accompanied by an aggravation of trouble in the finger. During the flow the finger became tender to the touch and very much more painful. This went on for four years, after which the pain and tenderness became continuous. She now sought medical aid. She was prescribed a mixture to take internally. It acted violently, but without any relief to the finger. She then consulted another physician who leeches, fomented, blistered, plastered, and bound, but to no effect. After nine months of this treatment she lost faith in the profession and applied to a bone setter, then to a Pad Doctor. At this stage the patient got married. This like menstruation aggravated the pain in the finger. In due time, the patient became a mother. She noticed that during the lying in period and nursing the finger pained her very little. She now, at the advice of her husband, had her finger opened. A careful search, under chloroform, failed to discover anything abnormal, and the nerve leading to the painful spot was severed. This had the desired effect, but as soon as the wound healed the pain returned with greater severity than ever. She noticed soon after the operation that the painful spot was a little raised above the level of the surrounding skin. After this she wandered from one medical man to another, and finally dropped into my hands some eighteen months ago, at which time this history was taken.

Present Condition. Patient looks pale, anaemic and careworn, suffers from violent headaches, otherwise general health fair; Pregnant three months and for the third time.

Physical examination of finger reveals considerable wasting and a scar one inch long on its ulnar side. About the centre of scar is an extremely tender, slight elevation, bluish in colour, as if caused by a dilated vein. Surrounding this spot, which is not larger than a split pea, is an oval area of extreme tenderness, about 4 lines in breadth by 8 in length. The papillae in this space are hypertrophied and seem to be arranged concentrically around the raised spot. The veins of the finger are considerably dilated. The slightest touch caused the patient to shrink, and pressure of any kind is intolerable. The whole course of the ulnar nerve is tender, some points more so than others. Pressure upon these causes the finger to start paining. Owing to the extreme sensitiveness of the painful area in the finger the patient seldom ever uses her arm.

Diagnosis. Three conditions were considered as possible cause. These were, first, local; 2, central; 3, reflected. Of the local conditions which suggested themselves were, 1st. An affection of one of the terminal organs of touch preferably a hypertrophied condition of a Pacinian corpuscle. 2nd. A foreign body pressing upon some part or branch of the ulnar nerve. 3rd. A growth or tumour involving the nerve at the seat of pain, or in some part of its course. Of the central conditions the only one which suggested itself was some minute growth in the brain involving a few of the cells from which the fibres distributed to the painful area took their origin. Of the reflected causes the ovaries came in for serious consideration. The patient was fully convinced that her trouble arose from some uterine disease, because a certain medical man had told her so, and that the treatment which he addressed to the womb was more successful than any other she had received. The fact that the patient was worse during her menstrual periods gave colour to this assumption, also the fact that during her lying in and nursing the finger gave little or no trouble. But her third confinement was an exception in this respect, and the ovaries as a possible cause were no longer considered. All centric causes were also discarded. The elevation at the seat of pain

might have been caused by the previous operation, and it served but little to clear up the difficulty, especially as nothing abnormal was found when the finger was opened. Still the probabilities were strongly in favor of some local trouble and of these my mind rested upon some malformation or hypertrophy of one or more Pacinian corpuscles.

Treatment. I accordingly advised excision of the whole painful area. From the patient's previous experience of an operation I had much difficulty in inducing her to submit to another; in view also of her being three months pregnant it was decided to wait. Eight months after confinement I obtained the patient's consent to an excision. Before operating I visited Boston and explained the case to some of the men on duty in the Massachusetts State Hospital. One man advised section of the nerve, but another had seen several cases of the same nature and explained that the trouble was invariably owing to a small tumour pressing upon the nervous filaments at the seat of pain and that the only treatment was its removal. Against this, however, was the fact that the finger had been opened and that a very careful and tedious search failed to discover anything. I however determined to excise, and on the 14th Jan'y. removed the whole painful area, part of which I now exhibit. The other part I have utilized for microscopic sections, two of which are before you for examination. At a little depth below the skin and lying close to the bone was a small round body the size of a pea, and quite soft. Under the microscope it presents a fibrocellular structure and a distinct capsule. I could not discern any nerve communication which would account for the extreme sensitiveness of the part. Evidently the pain was due to pressure on several of the nerve endings in the pulp of the finger.

The failure of the previous operation was due to the fact that an Esmarch was not used in the operation, and that as the tumour was small and quite as soft as the finger pulp, the constant oozing of blood obscured the view. I used a common rubber tube wound round the finger, and after the first incision which was made down to the bone, the tumour became visible. The patient since the operation has been quite well.

M. CHISHOLM.

Halifax, Feb. 20th, 1889.

## TWO CASES OF VARICOSE VEINS SUCCESSFULLY TREATED BY EXCISION.

BY N. E. MCKAY, M. D., M. R. C. S., ENG.,

Surgeon to V. G. Hospital.

IN reporting the two following cases of radical cure of varix by excision, I do so, not because I have anything new to offer to the profession, but chiefly to show that this operation although apparently more formidable, is not any more likely to be followed by untoward results, if performed with strict antiseptic precautions, than are the other operations recommended in our text books on surgery for the same purpose. It is preferable to any of the other operations since it does not enhance the danger of complications, and since it completely removes the disease.

Our text books seem to teach differently. For instance, Mr. Holmes in discussing the merits and deficiencies of the various operations in vogue for the radical cure of varicose veins, in his *System of Surgery*, 3rd edition, says: "A good and expeditious plan is that recommended by H. Lee, by whom it is thus described, 'a needle is introduced beneath the vein or veins to be obliterated and an S ligature passed over its extremities.'" Further on in treating of *subcutaneous division* he says: "Subcutaneous section of the vein is generally all that is necessary and is preferable to any other mode of operating, as it effectually obliterates the vessels without leaving an open wound." While in speaking of the operation of excision he says: "It is evident that there can be few cases of varicose veins to which so very severe a proceeding can be justifiably applied." Indeed he goes a step further and says: "The patient, if wise, will be content with the palliative measures of a more simple character." Again *Grant* in contrasting the operation of subcutaneous section

with that of excision of veins, says: "Subcutaneous section of the veins, without placing a suture-barrier on either side of the divided portion to guard either aperture is always perilous. \* \* \* Excision of a small portion of the vessel is equally hazardous as attested by Sir B. Brodie, although antiseptic precautions may do something to redeem the character of the procedure." Now, notwithstanding this, I never saw any other operation performed on veins in the London hospitals, and in these, as well as in the few cases which I have had myself, the operation was followed by no bad results, and effected a complete cure.

*The following is a Report of two of my cases:—*

CASE I.—E. D., single, painter, aged 37, was admitted into the V. G. Hospital on March 15th, 1887, suffering from chronic synovitis of left knee joint and a varix of long saphenous vein of same leg. The varix was confined to the part of vessel between knee and ankle. The synovitis was first treated. His general health was good. There was nothing of interest either in the family history or previous history or occupation of patient.

Patient was anxious to have the varix cured, and he willingly agreed to have an operation performed with this end in view. On the 22nd of September the operation of radical cure by excision was successfully performed.

*Preparation.*—On the morning of day of operation the skin in neighbourhood of the varix was shaved and washed thoroughly with soap and water and 1 in 20 carbolic acid solution.

*Details of Operation.*—The patient being Etherized, I applied an Esmarch bandage, and again washed the skin thoroughly in the neighbourhood of seat of operation; then made an incision 7 or 8 inches in length over the varix, and in line with it, through skin and areolar tissue so as to expose the vein. This being done I carefully dissected the upper end of vessel from the surrounding tissue, lifted it up, tied a double ligature (Catgut) around it and divided the vessel between the ligature. I then gently raised the varix from its bed, and as I did this each branch entering it was similarly treated, as was also the lower end. The wound was now thoroughly washed in carbolic solution 1 in 40, the Esmarch removed, the bleeding, which was slight, stopped, and the edges of the wound were brought in perfect co-aptation with catgut sutures, a catgut drainage being previously inserted in the entire length of the wound. The dressing was then applied in the following way:—A piece of protective about an inch in width and an inch longer than the incision was laid over the wound to protect the latter from the irritation of the antiseptic, and over this was laid a piece of gauze dipped in carbolic solution 1 to 40. This constituted the "deep dressing." Outside of this was applied the superficial dressing, which was formed of a layer of carbolic gauze with a macintosh beneath the outer layer, the dressing was held in position by gauze and cotton bandages. The operation was performed and dressing applied under a spray of carbolic acid. To ensure absolute rest to the part, a long straight back splint was applied.

On the 30th September, the 8th day after operation, the first dressing was removed under the spray, and union by first intention found to have occurred. The drainage was removed and left out and a similar dressing to the first applied. Had a little trouble in getting lower end of wound to heal. The delay in healing was due to irritation caused by the ligatured end of vessel which lay in the wound. But the application of a pad and compress over the vein, an inch or two below the wound, made the opening heal in a few days. Temperature remained normal throughout. Patient was discharged cured on the 17th October, 1887, the 25th day after the operation.

CASE II.—J. F., single, aged 21, farmer, was admitted into the V. G. Hospital on November 18th, 1887, under Dr. Black, the Surgeon on duty for the month. Patient's general health good. \* \* \* \*

On going on duty in the V. G. Hospital in the month of January, 1888, I found the patient in the following condition:—His general health was good; a small healing ulcer on the shin, and a large varix of the long saphenous vein between the knee and ankle.

On the 17th day of January I successfully removed the varix by excision. The operation was performed as in case I, with

strict antiseptic precautions; and the antiseptics and kind of dressing employed were also similar. The details of operation were much the same, with the following slight modifications, viz.: That on raising the vessel from its bed, I made an assistant hold the skin and areolar tissue at lower end of wound, well retracted, so as to enable me to tie the vessel as far under the integument as possible; and instead of inserting the drainage in the entire length of the wound, I brought it not nearer than an inch to the inferior angle of the incision. My object in doing this was to get rid of the irritation that might be caused by the ligatured end of the vessel, and thus avoid having any trouble with the healing of lower end of wound. In this I was successful. The incision in this case was 7 or 8 inches in length. On the 8th day after the operation I removed the dressing under the spray and found union by 1st intention to have taken place. The drainage was removed and left out, and a similar dressing to the first applied and left on for 6 or 7 days. The temperature and pulse remained normal during the whole progress of the case; and the patient was discharged cured on the first day of March.

It is evident that any operation that may be performed for the radical cure of varicose veins must have for its object the obliteration of the vessel, no matter what mode of procedure is resorted to to accomplish this end, whether cauterization, galvanism, intravenous injections, acupressure, subcutaneous division or excision, it must necessarily produce venous thrombosis. Cauterization, galvanism and intravenous injections are modes of obliteration so questionable, as to their efficacy or their safety, that they need only be mentioned.

The operation of subcutaneous section, as recommended in most of our text books, is most objectionable, since by leaving open apertures in the vessel it is almost sure to be followed by serious results. This operation, as modified by Mr. Grant, seems to lessen the danger of sepsis; but the surgeon is never sure of completely obliterating all the venous channels leading to and from the varicose part. Besides, it rarely if ever succeeds in curing the disease. Sir B. Brodie speaks of it thus:—"I have always observed that if I cured one cluster, two smaller ones appeared, one on each side, and that ultimately I left the patient no better than I found him.

Acupressure presents all the objectionable characters of that recommended by Grant, with the additional dangers of sepsis and sloughing of the integument.

In the operation of excision the surgeon sees all the vessels leading to and from the varicose parts, lifts them all up and ties a ligature around each of them, so that when the operation is completed all the vessels are obliterated, and there is no open aperture of a vessel left in the wound, in consequence of which the danger of pyæmia and septæmia is lessened, as is also that of emboli. This operation, therefore, commends itself to a surgeon, because while it does not increase the danger of after complications, if performed antiseptically, it effects a complete and permanent cure.

#### A CASE OF ŒDEMA OF THE VULVA DURING THE LAST MONTH OF PREGNANCY.

MRS. W., aged 27 years, primipara, sent for me on the night of 13th Jan'y last. I found on questioning her that her last menstruation ended on 12th April, 1888. She might therefore expect her labour to begin at any time. She was not yet in labour, but said that she had sent for me because of a large and painful swelling about the privates. For the past three days she had kept her bed, as she could not sit up without pain. She was a strong, red faced woman, and said that during her pregnancy she had enjoyed excellent health, until about a month previously, when her legs began to swell, and she found it difficult to get about. She had only noticed the swelling about the privates two or three weeks ago.

On examination a large soft tumour was found occupying the place of the right *labium majus*, and measuring roughly

about 5 inches in circumference. Any attempt at making a *per vaginam* examination was too painful to be persisted in. The pale appearance of the swelling, its soft nature, and fact of patient suffering also from general œdema reassured me that it was a case of simple œdema, and not, as I feared before looking at it, a case of thrombosis. Under chloroform I made four or five incisions, about  $\frac{1}{4}$  inch long, into the tumour, and at once clear serum began to ooze out freely. In a quarter of an hour the tumour was considerably reduced in size, and having prescribed a diuretic mixture, and ordered the midwife to give an enema, I left.

Three days later labour came on, and by that time the *labium majus* was almost of its natural size. It was still slightly œdematous, however, and the *minus* was also a little swollen. The presentation was breech and position L. S. A. After delivery the œdema quickly disappeared and the quantity of urine passed soon increased to the normal.

This case was in the hands of a midwife, who was diligently pulsating the swelling. Had the patient herself not insisted on having a doctor on the night of the 13th the probability is, that she would have been allowed to remain unrelieved until labour set in; and then a serious difficulty would have been offered to the second stage of labour. The case being one of breech presentation the chances of delivering a live child would have been small.

It would be interesting to know from those of your readers, who have met with similar cases of marked œdema, what the presentation was in their cases, that we may form an idea whether presentation has anything at all to do with modifying the pressure and causing such a condition.

N. S. F.

*St. John's, Newfoundland.*

#### ON THE NATURE, CAUSE AND PREVENTION OF PHTHISIS PULMONALIS.

BY R. RANDOLPH STEVENSON, M.D., *Little River.*

THE discussion in the late Medical Convention in Paris, on the communicability of "Tuberculosis" through the agency of milk from diseased cows, together with certain questions on Sanitary Science, lately addressed to the members of the Medical profession in Canada, from the Department of Agriculture at Ottawa, induces me to offer the following extracts from my paper, read before the Halifax County Medical Society in May, 1871.

"The subject for discussion to-night is not new by any means. It (Phthisis Pulmonalis) has engaged the attention of some of the most profound thinkers and eminent savants in our time-honored profession, from the days of Hippocrates down to the present time, and it must still continue to claim our patient investigation and research until more satisfactory results can be obtained in the treatment of this most destructive malady.

"I will not take up time in giving the elaborate theories that have been advanced on the subject by our teachers of the past, or by the writers of the present day, but will commence by stating that Phthisis Pulmonalis may be defined as a decay, characterized by a consolidation of the lungs, followed by softening degeneration and purulent expectoration. At the same time a wasting of the body and other evidences of defective nutrition are always present.

"Three forms of the disease present themselves for consideration. The first, characterized by slight rigors and



“fever,—followed by cough, expectoration of viscid matter and great debility—assuming sometimes the appearance of a continued fever, with brown tongue, sordes on the teeth and delirium. The case may resemble capillary bronchitis or pulmonary congestion; but in spite of stimulants, blisters, and other remedial agents, the pulse becomes, more rapid and thread-like; the lips, face and nails assume a dusky hue; a cold clammy sweat covers the surface, and death usually closes the scene in about six weeks. A post mortem examination usually reveals an innumerable host of small globular substances, designated “Miliary Tubercles,” permeating the whole parenchymatous structure of the lungs. In a person predisposed to consumption these tubercles make their appearance with all of the violent symptoms of a zymotic disease, and life is destroyed by congestion, produced by the obstruction that these minute tubercles offer to the entrance of air into the lungs. This always occurs before any large amount of degeneration takes place. This form of the disease may be designated by the name of “acute consumption,” or in common parlance, “galloping consumption.”

“The second form of this disease is ushered in by cough, and an occasional hæmoptysis. The expectoration is not so viscid as in the first form,—crepitation, irregular respiration and pulse frequent, heat of chest and body far above the healthy standard. This condition is occasionally alternated by chills and night sweats. The expectoration now becomes purulent and clotty, auscultation and percussion reveal the progress of decay that is rapidly taking place in the lungs. This form may also prove fatal in a short time, but such is not generally the case. It may sometimes be checked by nutritious diet, stimulants, cod-liver oil, etc., and the patient may continue to drag along with the disease, in a slow form, for a number of years before death comes to his relief.

“In the third class (and by far the most common) the progress is much slower. It is usually known as “incipient consumption,” a disease that tends sooner or later to destroy the substance of the lung, consume the flesh and blood of the whole body, and is attended with the same fatal results as the preceding forms.

“Without entering into any lengthy discussion on the pathological or physiological constitution of “Tubercle,” I will state that medicines so far have been powerless in arresting the rapid types of this disease. In a few instances the slower forms have been rendered quiescent; few cases, however, are permanently cured. All cases that have been benefited at all, have been through pure air, a full and generous diet, and stimulants.

“To attempt to cure a disease that has baffled the skill of the most scientific medical men of the present age by the ordinary routine of medicines, is very much like trying to effect an impossibility; but to enlighten our fellow-man upon the great principles that govern life and maintain health is one of the prerogatives of the physician. It is his duty to stand upon the watch towers of Hygeia and warn the unwary from the shoals and quicksands of disease and death. He may stand powerless for good at the bedside of his unfortunate patient, contemplating the brilliant but sunken eye, the total destruction of muscle and adipose tissue,—all being gradually absorbed; but for all this, he can by the aid of science lend intelligent counsel to his fellow-man and point to him the road to health.

“From the foregoing remarks, it must appear that Phthisis Pulmonalis has been ranked among the “incurables.” Shall we content ourselves with this edict and do

“nothing more? No, our next duty is to try and check this “scourge” in its deadly march. How is this to be accomplished? The answer is, by certain hygienic and sanitary regulations, and by attention to those great natural laws that govern life and maintain health,—of these pure air, pure water, and nutritious food must ever take the front rank.

“Food, next to purity of the air, determines the degree of the physical well being of man. It gives beauty of contour to the form, builds up the marvellous structure of the brain, and bestows upon society more of grace and refinement than most of us are willing to allow. The amount of food required in high latitudes is much greater than in warm countries. Much also depends upon muscular exertion and mental excitement. Food must not only consist of material but power. Baron Leibig says, that the strength of man is in direct ratio to the plastic matter of the food. Lehmann declares that three points are to be considered in the diet of man. 1,—That which is requisite to prevent him from sinking by starvation; 2,—That which affords the right supply of nourishment for the perfect accomplishment of the functions; and 3,—That which indicates the amount of nutrient matter which may, under the most favorable circumstances, be subjected to changes in the blood. Hence, in a salt fish and potatoe diet, such as is extensively used in the Maritime Provinces, the carbo-hydrates, albuminous matters, the salts and the fats are not combined in due proportions.

“Alimentary substances are divided into two classes,—the nitrogenous, and the non-nitrogenous. Neither the one nor the other will support life indefinitely; if one or the other falls below certain limits, health declines, and ultimately life becomes extinct by inaction. To maintain health man requires organic and inorganic food. Of the organic, he wants nitrogenous substances for the use of the vital tissues for work, and saccharine or oleaginous for warmth. Of the inorganic, he needs phosphates for the bones, muscles and blood, and salt for its influences over the circulation and the secretions. Prof. Dalton says, that a man may be starved by depriving him of phosphates and salt, just as effectually as by depriving him of albumen or oil.

“Man, when compelled to hard labor, requires beverages and condiments; he wants coffee or tea or cocoa, or wine or spirits, he also requires salt, pepper and vinegar. To preserve a sound body, then, he requires a mixed diet, and that frequently changed, as the continuous use of oil, albumen and starch will produce a tendency to bilious rheumatic and arthritic affections, while a deficiency of oleaginous substances tends to produce scrofula, consumption, etc. What suffices at the equator would not sustain life at the poles. The ration of the quiet student would starve the active, stalwart lumberman of this country. Hence the wants of the system differ according to the degree of heat, the purity of the air, and the amount of physical exercise. The Bedouin lives on a few ounces of food, the rest is made up by the purity of the air and the indolence of the Arab. A life of moderation, the avoidance of bad air, and the extremes of heat and cold afforded the celebrated Cornaro the privilege of living to a great age, on twelve ounces of solid food, with fourteen ounces of wine per diem.

“The distinguished Milne Edwards maintains that the mean quantity of food required to sustain the life of man consists of sixteen ounces of bread and thirteen ounces of beef daily.—The beef to be from cattle killed in their

“ native pastures, when the flesh retains all its natural juices and sweetness. The flesh of all mammalia becomes almost worthless, and even poisonous, if confined for a length of time, as they generally are, *in transitu* to market.

“ Vegetable substances alone will not sustain life for a great length of time in any climate; but, as has been shown, there is a vast difference in the wants of man at the Equator and his actual necessities at the Pole. Nature requires for her existence materials of different kinds. Neither oil nor sugar will sustain life alone. There must be a combination of these to complete the process of digestion and assimilation. To feed a patient on arrow-root, tapioca and sago would be to consign him to a speedy death. Brown bread is the most nutritious of all the forms of the “staff of life.” It has been proven that dogs fed exclusively on white bread made from sifted flour died in forty days, but when fed on black bread (flour with the bran) they lived without disturbance of health.

“ Mayer has shown that in discarding the commercial bran we throw away fourteen times as much phosphoric acid as there is in superfine flour. In this bran are lodged the phosphates and nitrogenous compounds—the source of living tissues. The nutritious Graham bread, the coarse oatmeal of Scotland, and the black bread of Russia and Germany are examples. They contain all the gluten, all the phosphates and nitrogenous compounds, as well as the starch of the grain. We find that the British soldier receives in home service, of solid food 40 ounces; the seamen of the Royal Navy 39 ounces. The full diet of the London hospitals ranges from 25 to 31 ounces of solid food, besides from 1 to 5 pints of beer daily. The Russian soldier receives 50 ounces, the Turkish about 40 ounces, the French nearly 50 ounces, the Yorkshire laborer 50 ounces, and the United States Navy and Army about 50 ounces per diem. In all the diet tables from which these data are taken we find no mention made of fish, salted or dried; and in one instance only do we find the article of salt beef mentioned, and that is in the case of the English Navy, when the troops are on duty in the torrid zone.

“ That the climate of the British Provinces is not favorable for the consumptive, I will admit; and I would not recommend a patient suffering with Phthisis to remove from a more temperate climate to this latitude. But, nevertheless, the atmosphere of this country is remarkable for its purity, especially in the Maritime Provinces. This is proven by the character of the sickness that predominates here. We never witness those malarial fevers and those complicated diseases, in some form, of the stomach, liver and bowels,—such as are produced by the highly vitiated air in the paludal districts of Europe, or in the swamps and jungles of the southern portion of the United States. Scrofula, in its various forms, and consumption are the prevailing diseases of this country,—maladies that are evidently produced by defective nutrition, and the neglecting of sanitary regulations.

“ The presence of oxygen in the blood gives it its vivifying properties, aerated as it is through the respiratory apparatus; but to complete the great principles of excitation, impulsion and motive power, it must receive combustible and organizable material. Oxygen then unites with the carbon of the food in the blood of animals; carbonic acid is formed and heat evolved. Animal life is also sustained by respiration; and the blood owes its vivifying properties in a great measure to the oxygen which it receives from the respiratory organs. An unhealthy atmosphere manifests itself at once in the diminished nutritive powers of the

“ vital current; and the more feeble the respiration the less rich the blood. Thus oxygen enters by the lungs into the blood; and it also enters partly into the composition of the tissues; so that it is real food, and it is as necessary to the construction of the human body as the other forms of food which are taken into the stomach.

“ The air must contain the vivifying properties at their normal standard or it loses its force, and death is inevitably the result. About one hundred gallons of pure air per hour are received into the lungs, of which about one-twentieth of the volume inspired is oxygen.

“ Dumas asserts that oxygen is necessary to the conservation of the vitality and proper structure of the globules of the blood; and that the integrity of these organisms is one of the essential conditions to the arterialization of the pabulum of life.

“ Milne Edwards asserts that the great absorbing powers of the blood exists in the globules. The number of these globules in healthy blood is one hundred and twenty-seven out of one thousand component parts; but sometimes they are observed in disease to descend to sixty-five.

“ Simon and other physiologists have shown how a careful and nutritious regimen may increase these globules in the consumptive, bringing them up from sixty-four to even one hundred and forty-four.

“ It is unnecessary in this paper to dwell on the advantages to health from the use of pure water, as this theme has been the subject of careful investigation, coeval with the science of medicine. Suffice to say that potable water to be fit for use should contain no traces of vegetable or animal matter, neither should the sulphates, chlorides and salts of lime, iron and magnesia exist to any great extent.

“ Having shown how necessary wholesome food, pure air and pure water are to the preservation of life and health, and that defective nutrition tends to debility, and hence lays the foundation for Tuberculosis; and having pointed out some of the means to prevent it, yet to rid ourselves more fully of this scourge we must view it in the same light as other contagious diseases.

“ Pure tubercular matter constitutes the true material (whether from man or an inferior animal) by which Phthisis is propagated; and this morbid matter or germ (by a slower process) is as capable of communicating consumption, from one person to another, as is the specific contagious matter of small pox, measles or scarlet fever. That its dissemination through society has not been regarded with the same degree of fear and distrust is true; that it has proven more fatal than other acknowledged self-propagating maladies, is a melancholy fact too true to be denied. Why is this? Because the teachings of our time-honored profession have been in collision with the truth in regard to the real nature of the disease, and the remedies and means of prevention have been consequently impotent for good.

“ In support of this startling view I may mention that the late Dr. Rush, of Philadelphia, states, that Phthisis was unknown among the North-American Indians, prior to the discovery of America by the Europeans; and Dr. Livingston informs us that consumption does not exist in the interior of Africa; and only along the coast, where the natives come in contact with the whites, do they suffer with it. Dr. Hayes, in his celebrated account of the Arctic regions, informs us that he saw no case of consumption amongst the Esquimaux Indians. The South Sea Islanders knew nothing of this disease until they came in contact with the European, although its ravages are such now that it threatens to exterminate them. It prevails to

"an alarming extent under all those social conditions that favor the propagation of diseases of the Zymotic group; hence in some families all the members, except, perhaps, one or two, will fall victims to it. Parents will transmit it to their offspring; close and ill-ventilated houses, churches, and other places for public assemblies, are all favorable to its dissemination; consequently we are forced into the belief that it spreads through society by hidden germs contained in tuberculous matter that is thrown off by a person laboring under Phthisis. I have seen in my own practice a large family of children all more or less afflicted with consumption, yet the parents of these children were apparently free from the disease, as well as their ancestors, as far back as they could be traced.

"In conclusion, may we not hope that wise sanitary regulations, based upon a revised pathological view of the disease in question, may be inculcated by our teachers in medicine, and a more thorough and searching investigation of its ravages laid bare by incontrovertible facts. As long as the medical profession are content to rank it among the 'incurables,' or say that it is a disease that follows a high order of civilization, or that it seems to be hereditary, or some such excuse, just so long will we continue to slide along in the same old grooves of our ancestors, without attempting to meet the real issues in the case. If strict Legislative enactments are deemed necessary for contagious diseases, and quarantine regulations are proper to protect large communities from pestilence, why may not consumption be taken into the same category as all of those contagious and infectious maladies, whose scourge is not carrying to the grave half so many victims as consumption?"

These views are based on scientific facts, and were promulgated by me in the years gone by. Similar views seem to be just now agitating the minds of the medical profession, as well as of the public, much more than they did before the days of Bacteriology. It seems that the late "Medical Congress of Paris" decided that Milch Cows are subject to Tuberculosis, hence the whole fabric of one portion of the world's supply of nutrition for man seems to be endangered by the fear that this theory is true. If it is true, the days of the "fatted calf" are approaching an end. It matters not how contagious Tuberculosis may be in the human family, but when it invades the material interests of sordid man, the halls of legislation must be invoked and unremunerative duties placed on the Physicians of Canada, to ascertain whether the animals in domestic use are subject to Tuberculosis or not. It is a well known fact that the use of pork tends to produce scrofula, (from scrofa a sow, because swine were considered to be subject to a similar complaint) and the transition from Scrofula to Phthisis has long since been acknowledged by medical men. If the use of pork, when diseased, is dangerous to man, why may not "kine and sheep" be equally so, especially if it is proved that they have "Tuberculosis?"

MRS. VENEERING—"Really, my dear doctor, you must come to my ball. It is Lucy's coming-out affair, you know, and I shall take no refusal; none at all."  
 Doctor Bygfee—"Well, you see, my dear madam, I am a very busy man. My time is not my own."  
 Mrs. Veneering—"Say no more. Include the visit in your bill. There, I shall expect you. Good-bye."  
*Pittsburg Bulletin.*

## Hospital Practice.

GENERAL PUBLIC HOSPITAL, ST. JOHN, N. B.

NOTES BY DR. F. L. KENNEY, *House Surgeon.*

### Case 1.—Compound comminuted fracture of skull.

J—H—aged 19. Admitted January 4th, under care of Dr. J. W. Daniel. Was chopping trees in the lumber woods on January 1st, when by some means he was caught by a heavy falling branch and crushed to the ground. On admission on the morning of the 4th, in addition to a fractured clavicle of the left side, and two or three minor lacerations of the scalp, he was found to have an extensive depressed compound fracture of the skull including the greater part of the forehead, reaching on the left side to frontal protuberance, and extending into temporal line on outer side of supraorbital ridge; on the right side in an oval direction to middle of supraorbital ridge. Both eyelids were extensively ecchymosed, and the left eyeball was markedly protuberant. There was no paralysis, skin rather hypersensitive, would answer questions when spoken to, though answers were random ones, did not know where he was, face flushed—did not complain of pain unless touched, or when he moved, when he would cry out loudly, on account of pain from fractured clavicle—generally laid quite still, though talking to himself frequently. He was catheterized and a large quantity of urine drawn off. At 2.30 he was placed on operating table, and at the angle of fracture where most depressed—left frontal eminence—he was trephined with small trephine. Two spicula of bone from inner table each about one inch by half-inch were found driven through dura mater into brain,—they were removed—depressed portion elevated—incision was extended—in line of fracture towards outer angle of orbital ridge when that portion found depressed above, was here elevated above level of sound bone. This could not be replaced with a justifiable amount of force and it was left as it was. A slight amount of brain matter escaped during operation. Operation performed antiseptically as were all subsequent dressings. Pulse next day 96, temp. 101.3. Resting comfortably, takes food well, passes urine and feces voluntarily, and very particular in calling for assistance at such times. A zinc coil was kept constantly on his head. About the fifth day after admission, pus pointed at top of left eyelid and it was evacuated. The cornea ulcerated through, and the eyeball became completely destroyed, though no suppuration took place in it. From this time progressed very favourably, so that he would sit up in bed, knew everything, perfectly sensible, pulse and temperature normal—till the 19th, when he became very feverish, complained of sore throat, and inflamed gland under angle of left jaw—fauces covered with diphtheritic exudation. Rallied from this, though not as well as before, and by the 26th was again distinctly feverish with evident symptoms of cerebral inflammation. Operation wound had entirely healed. From this time patient continued to get worse, and died February 6th, over five weeks from date of injury.

*Necropsy.*—There was a semi-circular fracture of frontal bone extending from the external extremity of supraorbital ridge on the right side, upwards and across frontal bone to left frontal eminence, and then downwards ending in the internal border of the left zygomatic fossa. The roof of left orbit was fractured transversely, and there was a stellate fracture of its inner portion—at the centre of this stellate fracture was a minute opening. The meninges were inflamed and a collection of pus was present under left frontal convolution and extending under base of brain.

### Case 2.—Vesical calculus—*supra pubic lithotomy.*

A—McJ—aged 44. Had suffered from symptoms of stone in the bladder for about two years, and for the last year had suffered very much indeed. Though somewhat run down from suffering, was well nourished and in very fair condition. An attempt was made to crush the calculus by means of the lithotrite, but it was unsuccessful, probably on account of its size, which was considerable. On January 18th, Dr. Daniel performed supra pubic lithotomy, and extracted a large egg-shaped phos-

phatic calculus, measuring  $2\frac{1}{2}$  inches in its long diameter,  $1\frac{1}{4}$  inches in its short diameter, and weighing  $2\frac{1}{4}$  oz. Some bladder epithelium was closely adherent to its under-surface, and remained so, coming away with it. The operation was performed according to Sir Henry Thompson's plan: the rectal bag filled with warm water—the bladder was then injected with warm weak solution of carbolic acid as much as it would take, and a rubber band tied around penis to retain fluid. After linea alba had been divided, the scalpel was not used till bladder was reached, the dissection being done with finger nail. Two needles armed with silk ligature were passed through upper surface of bladder about an inch apart, and by this means an assistant held up and steadied the viscus till operation was finished. An opening was made in bladder with bistoury, large enough to admit forefinger of left hand, between the two ligatures, and the stone was felt occupying base of bladder. Owing to size of calculus it was necessary to enlarge opening in bladder, and this was done by gently inserting forefingers of right hand alongside the other, and gradually enlarging opening by separating fingers. The stone was then extracted without much difficulty. A catheter was inserted per urethram, and a drainage tube passed into bladder through wound. No attempt was made to close either the wound in the bladder or abdominal wall. A piece of lint soaked in carbolic acid solution was placed over wound, and patient placed in bed on his back. There was no shock from operation, patient coming to quickly and satisfactorily. During night temperature went up to  $101^{\circ}$ , but at time of morning visit on the 19th, it had gone down to  $98.8^{\circ}$ , with a pulse of 100. The urine which all came from wound was clear, and there was no pain or discomfort. Jan. 20th, pulse 98, temp.  $99.8^{\circ}$ . Catheter and tube both removed, and patient directed to lay six hours on one side, and six hours on the other, alternately. Patient progressed each day satisfactorily, and on the 22nd, or fourth day after operation, some urine came per urethram, and pulse and temperature alike were normal. On 26th, bladder was washed and soft rubber catheter passed and retained in situ, and the patient placed in bed in semi-recumbent position. No urine came from wound after the 29th, or 9th day after operation, and on the 31st, the catheter was removed, the patient undertaking to pass it himself every three hours, and he was allowed to be up and walk about the room. The patient was discharged February 13th, perfectly well, except that external wound was not quite healed over.

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### *Society Proceedings.*

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#### HALIFAX BRANCH B. M. ASSOCIATION.

*Stated Meeting, January 3rd, 1889.*

DR. W. N. WICKWIRE, Vice-President in the chair.

After the minutes of the previous meeting were read, Dr. Chisholm read notes of a case of abscess of breast, which from certain indications present, he feared might take on a malignant form. The patient was exhibited, nearly all present expressing the opinion that it could hardly be considered malignant as yet.

DR. J. F. BLACK read the following paper:—

Having lately, as most of you are aware, returned from a visit to Europe, our secretary suggested to me that some account of what I saw in a medical way might be of interest to the members of the branch. I have therefore tried to jot down a few of my recollections in a very unstudied way. When one has been over a large extent of ground the difficulty consists in knowing what to choose for mention, and how best to condense one's remarks within the limits afforded by a short paper.

Landing about the middle of May at Londonderry, I made Dublin my first stopping place. By the kindness of

Dr. Mapother I was enabled to see all of the larger hospitals under favourable circumstances. I shall only allude to the Rotunda which, as all of you are aware, is the great centre of Obstetric and Gynaecological practice in Great Britain. In regard to the former department I was chiefly interested in finding out to what extent antiseptic precautions were adopted in obstetric cases. I learned that each ward is used in rotation, and as soon as emptied is thoroughly cleansed and disinfected by frequent scrubbing and fumigation with sulphur before a new series of cases is admitted to it. I was told that absolutely no antiseptic measures, either preparatory at the time of delivery or subsequently, is employed as regards the patient, but that the utmost and uncompromising cleanliness and disinfection of the hands and appliances of the accoucheur are relied upon as the all important factor. The only other point I would mention is the free and early employment of forceps, the form preferred being what is known as traction forceps.

In the gynaecological service I noticed particularly the construction of the examining table, which if not very considerate of the patient's modesty is certainly most satisfactory for the purpose of the surgeon. Here too the very free use of plain water supersedes all antiseptic solutions. I was much struck by the great freedom with which the interior of the uterus was treated, both by application and by instrumental means, care of course being taken that the cervix should previously be well dilated. For washing out the cavity the favorite instrument was one of American invention and it seemed quite familiar to hear the frequent requests for the large or small "Bezeman." The frequent use of pessaries in displacements, the free local abstraction of blood by puncture, and application of pyrogallic acid through the cervix were other points noted.

With these brief notes of Dublin I must cross over to London where nearly all my time was passed. The great difficulty for a stranger in attempting to do Medical London, is to know how to begin and especially to know how much to try to do and what to leave unattempted. The number of hospitals is so large, the distance between them so great that one is very apt to waste a good deal of time before he learns how to economize it. I carried with me a large number of letters of introduction to various surgeons connected with hospitals. In every case I was most courteously received but in this regard I would say that there is no special advantage to be derived from such introductions, for the simple reason that so many from abroad daily present themselves similarly introduced, that with the best intentions the person to whom you are introduced cannot be expected to do very much for you.

A better plan I found was to go to any hospital of which you wished to see the practice, and ask for a member of the House Staff, who upon the presentation of your card, with the added statement that you come from abroad, will in nearly every instance be glad to let you make his rounds with him, and will be able to afford much more information than you could get from the visiting surgeon. In this way I visited all the important hospitals in London, selecting a few for frequent attendance, viz., St. Thomas', St. Bartholomew's, Kings College hospital and the Samaritan Free Hospital for Women.

To begin then with St. Thomas', undoubtedly the finest of the London Hospitals, and with the best surroundings on account of its situation on the Thames embankment, close to Westminster bridge, and thus free from the objection to nearly all others, that they are in the midst of densely crowded portions of the city. This may be considered a

model hospital in most respects, and is especially commendable from the size of the wards and corridors, and the simplicity and regularity of its plan. Here I saw at various times operations by Mr. Croft, Sir Wm. McCormack, Sydney Jones, and other surgeons. The most important operations being two for radical cure of hernia, removal of floating cartilage from knee, amputation of thigh, etc. Of course the interest consisted in the details and these time would fail me to give. The hospital seemed well organized and conducted in all respects.

At King's College Hospital the central figure of course is Sir Joseph Lister. It comes hard to one who has been always rather a pronounced Listerian disciple to acknowledge it, but I must confess to a feeling of disappointment when I first saw an operation in the home of antiseptic surgery, performed by the great originator of the method himself, and I could not but find myself contrasting the scene with an experience of a year or two before when in the theatre of the Roosevelt Hospital, New York, I used to see under the direction of our lamented friend, Dr. Sands, what has always seemed to me the beau ideal of a surgical operation conducted antiseptically.

Lister is certainly not a brilliant operator. The use of the spray has been totally given up by him, though I found it used in a sort of half hearted way in most of the London hospitals. The substitute at King's College is irrigation with Perchloride solution. Among operations I saw Lister perform was one for rectifying badly united fracture of femur and resection of the elbow joint.

Perhaps the most novel treatment which I saw carried out was the injection of a cavity of a large psoas abscess with iodoform. Lister was doing it for the first time with some degree of doubt, on the recommendation of a German surgeon, Billroth, I think. The abscess was tapped and 20 ounces drawn off through a canula, then a solution of carbolic acid (1 to 100) was injected until it came away clear, after which three and half ounces of a solution of iodoform in glycerine (1 to 10) was injected into the abscess cavity and left there, the opening being tightly closed up by sutures. The chances of iodoform poisoning seemed, as Lister remarked, very good, about 150 grains of the drug being used, but no bad effect followed, and some weeks after the case was reported to be doing well, a second injection of 90 grains having been made.

The dressing chiefly used in Lister's wards now is alembroth gauze, (though he is constantly experimenting with others,) it being made with a combination of Bichloride of Mercury and Muriate of Ammonia; its chief advantage is supposed to be that it is less irritating, but Lister still further guards against this by washing the first layer in water. The edges of small dressings are made adherent to the skin by collodion. Silk worm gut is largely used for sutures, and kangaroo tendon for various purposes.

At King's College Hospital too I had the privilege of seeing the practice of Dr. Playfair's wards through the kindness of Dr. Carleton Jones, now of our city, at that time resident accoucheur of the hospital. I was particularly interested in Playfair's use of the Apostoli method, he being one of the few London surgeons who have embraced the new faith, but of this more anon.

Coming next to speak of St. Bartholomew's, I think I may say I was more pleased with it than any of the others. I was especially struck by the amount of interest in the hospital shown by the attending staff, and the good feeling which seemed to prevail among its members. This was more particularly noticeable at the weekly consultations which I

generally tried to be present at. On this occasion all important or doubtful cases are brought into the theatre, and in presence of the students each member of the staff examines the cases and states his opinion of the diagnosis, prognosis, and proper mode of treatment. Saw here Mr. Thos. Smith do his well known cleft palate operation.

Guy's Hospital I only visited on two occasions. On the first I was shown very thoroughly through by the Resident Medical Superintendent, and noticed especially the magnificent wax models in the museum and the elaborate system of ventilation. On a second visit I saw Clement Lucas operate for cleft palate. They were greatly lamenting the recent retirement, on account of age, of Mr. Bryant, whose name I still saw on many of the patient's cards.

At the Soho Square Hospital for Women, an opportunity is given of seeing an immense number of gynaecological cases, but they expect you to take out a regular three months course of instruction which involved giving up more time than I had at my disposal. In this department I very much preferred the Samaritan Free Hospital for Women, and it was to this institution that I devoted perhaps more time and in a more satisfactory way, than to any other. Here abdominal surgery is to be seen in its best aspects, at all events in London, and probably anywhere in the world. Originally started by Sir Spencer Wells, the work is now carried on chiefly by three men, Knowsley Thornton, Granville Bantock and Mr. Meredith. The hospital is a very small one being simply the adaptation of a private residence on Lower Seymour Street. It has a number of small rooms and each patient is operated upon in the room in which she and her nurse are to remain. Only medical men are admitted to operations, and before admission each one is required to sign a book to the effect that he has not been near a dissecting room or any infectious case of disease for a fortnight. As only a limited number are permitted to be present at each operation you get close to the operating table and can see for yourself all details. Visitors from all parts of the world may be noticed here. Thornton and Meredith still use all antiseptic precautions in their operations, including the spray, which is turned on at the moment of opening the peritoneum. Bantock, on the other hand now uses no form of germicide; water alone is used, and that not specially prepared. At the time of my last visit he had had a run of 85 cases of abdominal section, in which no antiseptic had been used, without a single death. He washes out the abdominal cavity and employs drainage more frequently than the others, though all drain in cases in which washing out is considered necessary. In hysterectomies the pedicle is transfixed and surrounded by a wire of Delta metal with instrument on principle of an ecraseur, the wire being tightened from day to day and being fixed upon the abdominal wound. Very many points of detail that it would be tiresome to enumerate were noted here.

In Glasgow I was present at the annual meeting of the British Medical Association, and had the honor of being received as the representative of the Halifax Branch. As you have all read the reports of the proceedings of the meeting in the Journal, I need not enlarge much on the matter. The meeting was a very successful one and largely attended, the concurrence of the Glasgow Exhibition having a favorable influence in this respect. The chances of meeting, seeing and hearing many of the men whom one has heard of all his life as being at the head of the profession, is one not to be forgotten. The place of meeting, the University of Glasgow, was admirably suited to the purpose. Owing to the division of the work into different sections one is able only to attend a limited part of the meeting and has to choose among them.

I selected the sections for Surgery, Gynaecology and Diseases of Children. I was also present at discussions in other sections. The discussion on Apostoli's method of treatment was very interesting, opened as it was by Apostoli himself. In this section too a very animated discussion occurred on the subject of forcible dilatation of the cervix uteri, the majority seeming to favor that procedure. In the section for Diseases of Children the discussion on Diphtheria was of most importance; Jacobi, of New York, took a leading part, and Dr. Waxham, of Chicago, described the method of intubation of the larynx, which seems to be comparatively untried on the other side.

It struck me in regard to the discussions in all the sections that there was a lack of thoroughness about them, explainable doubtless by the immense number of papers and subjects, and the necessity for limiting the time given to each one. In the general meeting the address by Clifford Ailbut on medicine, was scholarly and exhaustive, but was marred by a poor delivery which made it difficult to appreciate in so large a room as the Bute Hall.

Sir George MacLeod's paper on the "Progress of Surgery in the last Fifty Years," was well written and delivered, but contained little that was new or striking. The address that produced the sensation of the meeting was that by Dr. Macewan, of Glasgow, on "Brain Surgery." As it was published in full in the Journal I will not say anything about it except that it seems to mark a new era in the treatment of brain disease. Its delivery was met by the most enthusiastic reception, and seemed to carry the audience by storm.

Of the Glasgow Hospital I will not say much. The Western Infirmary, a comparatively new structure, is a very fine one and impressed me as being very well appointed in all respects. At the Royal Infirmary we had the opportunity of seeing Dr. Macewan do several of his operations for Genu Valgum by subcutaneous division of the femur above the condyles. Here too he impressed me very strongly with his thoroughness, his exactness as an operator and general force of character. He employs antiseptic measures including the spray, although he admits that were he beginning de novo he would not probably now consider this essential.

In Edinburgh on account of its being vacation season I was not able to see much practice. The Infirmary is certainly one of the finest hospitals in Great Britain, and the new buildings for the medical department of the University leave little to be desired, being far ahead of anything I have ever seen, and only approached by the new building for the College of Physicians and Surgeons of New York, my own *alma mater*.

In Paris I was only able to see the lesser lights, all the leading men being *en vacancé*. I was not very favourably impressed by the Parisian hospitals.

While being greatly pleased and interested with all I saw in the hospitals visited, still I must confess that to a man accustomed to the hospitals of the larger American cities, New York, Boston and Philadelphia, old country hospitals, especially London hospitals are disappointing in the general impression they give a visitor. The wards are for the most part low and dark, and want the bright cheerful look of an American hospital. Of course this is to be explained by the age of the buildings and the fact that they are necessarily situated in densely crowded sections of the city, but to my mind there is a practical application of means to ends, an amount of attention to little things and a general appearance of being up to the times in the institu-

tions on this side of the Atlantic which one does not notice on the other side, as far as I saw them.

I have come back with a better idea of American surgeons and surgery than I used to have, and feel now that they have no reason to dread being compared with the men whom one has been taught to consider unapproachable.

Dr. G. E. JeWitt reported a case of "Multiple Abscess of Liver," now under his care, the full details of which will be given in a future issue.

Dr. Fowler, A. M. D., reported a case of compound fracture of skull complicated with laceration. No information had been obtained about the reception, there were no signs of compression, and the man died suddenly.

P. M. examination showed extensive fracture of the base.

#### MEDICAL SOCIETY OF THE STATE OF NEW YORK.

At the eighty-third annual meeting, held in Albany, beginning on Tuesday, Feb. 5th, several interesting matters were touched upon before the numerous papers on stated subjects were read.

The president referred to the fact that Judge Learned, of the Supreme Court, had recently given a decision to the effect that no man could be confined in an asylum on the certificate of two physicians unless it was shown that he was dangerous to himself or others. A suit had lately been brought by the man in whose favor the decision had been made, against two physicians who had issued a certificate of insanity in his case after satisfying themselves of certain mental delusions which had led him to imagine that his wife and daughter had been trying to poison him. No damages had been awarded but the future liability to such suits deserved to be remembered.

The committee on legislation was instructed to use all honorable means to have the bill referring to libel suits so altered that those commencing suits for malpractice should be required to give bonds for all costs; as is required in cases of suits for libel against publishers and editors, and in view of the fact that 90 % of all suits brought for malpractice are for blackmail.

The committee on legislation reported in favor of a bill to exempt medical supplies and surgical instruments from duty.

A number of valuable papers were read of which we may mention:

*The Municipal Control of Diphtheria*, by Dr. Chas. Stone, of Amsterdam; in which he advocated a rigorous and complete provision for the isolation, disinfection and sanitary prevention of the disease.

Dr. B. F. Sherman, of Ogdensburg, remarked, in connection with a paper on typhoid fever, that in country practice it was much easier for a family to believe that God had seen fit to remove a beloved member from their midst, than for them to take a statement from a physician that it was due to filth about the premises that death had come among them.

*The Treatment of Chronic Constipation by Electricity*, by Dr. A. M. Hammond of New York:—Dr. Hammond speaks of the great value of electricity in permanently overcoming constipation, and the neglect of this means by both general practitioners and also by specialists. He had relieved cases of apparent fecal obstruction in five minutes, after months of ineffectual catharsis, and in one case had thus cured sciatica. He used a mild galvanic current, the negative electrode being passed well within the sphincter.

Faradic currents were of use only to strengthen the muscles of the abdomen, and so aid in defecation.

*The Efficacy of the Older Methods of Treating Nasal Disease, contrasted with those of to-day*, by Dr. C. C. Rice, of New York:—Dr. Rice said that our knowledge had especially advanced concerning the nature, cause and treatment of hypersecretion from the nasal mucous membrane. We had found that medication by solutions or sprays, failed to change its state at all. We had learned the relative importance of inflammation of the larynx, and that it was secondary to catarrh in the nasal passages.

The occlusion, changed color, and hypersecretion observed in the nasal cavity, often invited astringent remedies which only increased these conditions, for we now know that we had to deal with erectile tissues, a true cavernous body, any stimulation on the surface of which caused turgescence.

The hypersecretion itself differs from that in ordinary mucous membrane. It was a serous secretion. We had learned in the past ten years to use atomisers for cleaning the nose only, to employ cocaine and the galvano cautery.

The President gave an able review of the subject of medical expert testimony. He referred to the misunderstandings and perversions of necessarily complicated truths which arose whenever a man trained in medicine attempted to impart his views to an uneducated audience.

He suggested as a partial remedy for the evils inherent to the present system by which lawyers handled the medical expert of their own selection, and the expert put forward by the opposing lawyer entirely with a view of winning their case, that a board of three or more experts be appointed by the court, one or more being nominated by each of the opposing counsel, and the odd member by the court; that these experts should be paid by the court and the charge equally divided; and that questions on medical matters should be submitted to, and answered by the board in writing.—*N. Y. Medical Journal.*

### Correspondence.

*Editor Medical News:*

SIR,—A meeting of medical men of Prince Edward Island, was held in Charlottetown, January 12th ult., for the purpose of discussing a Medical Act for this province.

The question of medical law and registration was discussed by all present, and it was the unanimous opinion that this province should have a Medical Act, thereby placing the profession on a level with the other provinces of the Dominion.

A committee was appointed to prepare a bill to present to the legislature. A very reasonable bill has been prepared, similar in its provisions to the British Columbia Medical Act, and will be presented to the legislature at the next session.

F. F. KELLY, M. D.,

Charlottetown, P. E. I.

Secy. of Committee.

### THE DEPARTMENT OF MARINE VS. MEDICAL MEN.

MEDICAL men are occasionally called upon to treat sick mariners and furnish the bills to the Department of Marine and Fisheries, where they undergo examination, and if not approved by Mr. Wm. Smith, are clipped and cut down. The department have a rule to pay medical men \$1.00 per visit where no distance is travelled. In a recent case of

severe Rheumatic Iritis complicated with *Epi Scleritis* and Meningeal pains, I had occasion to make 3 visits some days, and two visits most of the time, as the treatment could not be carried on by any person at hand. Fancy my surprise when I had been informed by Mr. Smith that one visit a day is all that the department would allow.

It is high time that the question of the rights of medical men should be thoroughly ventilated. I hold that the government has no power to arbitrarily cut down the services of a medical man, for if they have power to keep back a portion, they have power to take the whole, and if the question of visits is to be decided the deputy officer in the marine department is not by any means an authoritative competent officer to decide upon this matter.

Medical jurisprudence of all nations concede that the physician or surgeon in charge of a case is the only proper judge of the necessities of the patient in this particular, and may exercise his discretion accordingly. The number of visits which a physician may make in any given case cannot be pre-determined. How, therefore, is the department of marine going to decide away in Ottawa, that more than one visit is unnecessary?

For my own part I take the ground that an honorable medical man would visit a patient only when in his judgement and opinion a visit was necessary, and that being the case I hold that when professional services are rendered to the government according to their own fee bill they have no right to cut the account down—they may arrange a compromise, but if they have power to keep back a portion, they can keep back the whole. This I deny. Medical men all over this Dominion doubtless have been more or less annoyed by the arbitrary conduct of this individual, and the sooner the question is considered on its merits the better for the profession.

The department of marine acts a very dishonorable part when accounts being rendered for services performed according to their own fee bill, they refuse payment. This conduct would not be tolerated for a moment if made by an individual or a corporation, but having the Divine Royal Prerogative behind them, you cannot sue the government without obtaining the consent of His Excellency the Governor-General, and the amounts are so small that medical men would rather suffer wrong than prosecute their rights. And the expenses attending litigation would cost them more than they would gain. The knowledge of this doubtless makes Mr. Smith a little too ready with his clippers. The MARITIME MEDICAL NEWS will afford an excellent medium for the profession to make known their grievances, and I think it is high time they organized and made their influence felt and compelled the department to do simple justice in these matters. At all events I believe the rights of medical men are not sufficiently well understood.

The common law sets no limitation to fees provided they be reasonable, and within this rule a practitioner is allowed discretionary powers, and may charge more or less according to his own estimate of the value of his services. It is only where an unreasonable and palpably unjust charge is made that courts will interfere to reduce the claim to a more equitable one. But in the case of the government the difficulty is, we cannot get at them by the law, they cannot be sued without their own consent, and their agents are not liable.

The Minister of Marine is a Nova Scotian and a clear headed man, the son of a worthy sire. I hope he will cause his subordinate to do justice in these matters. I hope every one who has a grievance against the department will speak

out and make the matter known. Let information be given to our representatives in parliament so that this matter may be set right.

Yours truly,  
R. MACNEILL

ALL agree with me when I say, that a large number of deaths occur annually from communicable diseases. But when I say that all communicable diseases are preventable, then I am asked to modify that statement.

The old idea was that Scarlet Fever, Measles, Whooping Cough and Chicken pox, must be had by all children, and the earlier in life the better. As a matter of fact, nothing could be wider from the truth. These diseases are *not* a necessity with childhood, and children should be carefully guarded against them. For the last three or four months, Measles have been epidemic in Halifax City and County, and Whooping Cough has been prevalent in the City and yet, absolutely nothing has been done to prevent their spread. Why is this? Is Halifax so populous that we need the destroying angel?

Now these diseases should not have spread beyond the house or houses in which they first appeared; but they did spread, and some one is guilty, criminally guilty. The blood of at least a score of persons, young and old, "crieth for vengeance."

To prevent the spread of contagious diseases has always been considered expensive, and for this reason more than any other, these diseases, which at first were confined to one house, have become epidemic and have swept off hundreds of our race, costing, in dollars and cents, more a thousand fold than the most expensive preventative measures.

With the aid of some statistics gathered from different sources I will endeavour to show that our City is every year losing thousands of dollars because of this penny-wise-and-pound-foolish system of paying no heed to the "destruction that walketh at noon-day."

According to the mortuary statistics for 1887, the number of deaths in Halifax from all causes was 727. Of this number we can safely estimate the number of preventable deaths at 10% or 72.7 and placing a money value on each of \$1000, we have a death loss of \$72,700.

For every death we have at least 20 cases of sickness or a total of 1454 cases, and each case of sickness costing, say \$25, (a very low figure) we have a loss by sickness of \$36,350. To this add the death loss and we have no less a sum than \$109,050 as a loss to the fair city of Halifax by preventable disease and death. Besides this we have as results not included in the above, Deafness, Blindness, Insanity, Chronic invalidism and poverty, with all their attendant misery and expense. A large portion of this can be saved by judicious preventive measures.

There are several reasons why the members of our City Board of Health cannot, as at present constituted, accomplish this. I will mention two. (1) Because they are not qualified by a scientific knowledge of the causes, and of the methods for preventing the spread of diseases. (2) Because they cannot, nor can we expect them to, attend to the public good without remuneration.

In order then that the people be not left to suffer, let the City procure the services of at least two physicians or sanitarians, whose work shall be to prevent as far as possible, the spread of all contagious diseases, attend to the sanitary conditions of the city, etc., and let them be paid out of the

public funds a salary that would enable them to subsist without going into general practice, and then the City can claim their whole time and talent. This would cost say \$5000, and with an additional \$5000 for the carrying out of preventive measures we would diminish the loss at least 70% which would mean a saving to the City of at least \$88,145 per year. This is no flight of thought into the realms of imagination nor creation of a brain disordered by horror of loss, but a plain statement of facts, fully borne out by the best scientific research.

T. A. S.

### THE WEIGHT OF THE BRAIN AND OF ITS PARTS IN INSANITY.

DR. TIGGES' paper on this subject fills 125 pages of the "Zeitschrift für Psychiatric," (xiv. Band, 1tes and 2tes Heft.) The learned author comes to the following conclusions:—"With a greater height of the body we have in general a greater weight of the brain. Tall people have heavier brains than short people. This increase of the weight of the brain with the stature is greater with women than with men; perhaps greater with the sane than with the insane. The relative weight of the brain to the stature increases with the stature, *i. e.*, the relative increase is greater with tall people than with people of middle size. The hemispheres, cerebellum and base of the brain all increase in weight with the stature. In women the increase is regular, *i. e.*, all the parts increase in proportion to the body itself, though the relative weight of the brain becomes smaller.

On looking over the table of average weights collected by Dr. Tigges, the heaviest brains seem to be Hanoverian; next come the people of Westphalia and Baden.

The great weight assigned to the brains of Hanoverians comes from the tables of Krause and Henle. The former observer gives 1,461 grammes for the average weight of males, and 1,300 for females. The number weighed by them is not stated, but they were brains of lunatics. Bergmann weighed 152 male and 90 female brains of Hanoverians, and gives the average weight as 1,372 for males, and 1,272 for females. The average brain weights of different nationalities is stated by Tigges in the following table. It is singular he does not give the average brain weight of Italians, for which, surely, there is material enough in the contributions of Morselli and Seppilli:—

	Grammes.	Grammes.
	MALES.	FEMALES.
Hanoverians, Westphalians and Badeners.....	1,433	1,284
Mecklenburgers.....	1,362	1,244
Different German Nationalities (Rud. Wagner).....	1,362	1,242
Saxons and Swiss.....	1,354	1,240
Bavarians.....	1,362	1,219
Austrians (German).....	1,297	1,157
Other Austrians.....	1,347	1,171
Russians.....	1,349	1,216
Scotch.....	1,423	1,267
English.....	1,326	1,200
French.....	1,340	1,222
All Europeans together (Paris).....	1,367	1,204

IN that form of dyspepsia characterized by furred tongue with enlarged red papillæ, pain and distress at the pit of the stomach after food, acidity, and "heartburn," ten minims of tincture of nux vomica with five minims of Fowler's solution of arsenic, in a goblet of water, taken slowly in the early morning, frequently acts most beneficially.—*Medical World.*



# The Maritime Medical News.

March, 1889.

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WE are not in possession of a knowledge of all the causes which produce a greater tendency to the spread of infectious disease at one time than at another, or in one year than in another, but the fact that such a tendency exists is recognised, and it is usually found to be the case that when one contagious eruptive fever is epidemic in a community other zymotics are more than usually prevalent. Thus the atmospheric and other conditions which are favorable to the spread of varicella are equally favorable to the spread of variola, and though there is no apparent connection or similarity between them, this tendency of the two diseases to travel in couples has been frequently observed.

During the past year and present winter the epidemic influence referred to, seems to have been present in Saint John to a very great extent, and measles, scarlet fever, diphtheria and croup have been very prevalent and the cause of a large number of deaths. To this category must now be added Rötheln or German measles, a disease fortunately accompanied with no or, at most, very little danger to life, and but slight inconvenience to the patient in the majority of cases.

This affection seems to have had a rather difficult task to establish its claim as a distinct disease, and for a long time was classed either as scarletina or measles, according as its symptoms seemed to incline more to, and partake more of the nature of one or the other of these diseases. It is only about twenty years since Tanner's well known Manual of Practice was published, and that author makes the following reference to it. "It is doubtful whether a disease should be described which presents many of the characters of measles and

scarletina conjoined; and which has been described as Rubeola, Rötheln, or Scarletina Morbillosa, or a Hybrid of Measles and Scarlet Fever. I think such a special description unnecessary, because we know that measles and scarletina may exist in the body at the same time; and hence the affection will be merely a compound of the two." And so the author dismisses the subject. The more recent authorities describe the affection more particularly, and the fact that it does not protect from measles or scarletina, but that it does protect from a second attack, leaves no doubt that it is a disease *sui generis*. The symptoms as laid down in text books are marked enough, but like most other diseases, purely typical cases are not always met with, and as a matter of fact, difficulty is frequently encountered in making correct diagnosis. Its presence in St. John at this time has had one peculiar though not surprising result, viz: that many people in whose family this exanthem has been present, and who have called in no medical advice, have supposed that their children have had scarletina; they have congratulated themselves on their easy escape, and have relaxed diligence in keeping clear of the more dreaded disease. In such cases when the children are again taken sick and the physician is called in and diagnoses scarletina, his statements are at first received a little incredulously, and he is asked if a second attack of scarletina could occur so soon.

The more important symptoms as noticed in this city are a small discrete, non-crescentic, irregular shaped eruption, coming on frequently without previous sickness, accompanied with swelling and soreness of lymphatic glands under the ear and in the neck, and sometimes with slight soreness of the throat. The eruption may disappear in a few hours and rarely continues more than two days. In some cases there is slight lachrymation, the individual spots are larger in size, more or less confluent, and fade into a brownish color, and the attack is very similar to ordinary measles. But the chief interest in the affection is in those cases which more nearly simulate mild scarletina, and deceive parents into the idea that their children have had that disease.

THE Boston Medical Library Association gave, on Tuesday evening, January 29th, a reception to Dr. Oliver Wendell Holmes, its president from 1875 to 1888, when his medical library was formally presented to the Association and accepted. Remarks were made by Dr. Holmes, Drs. D. W. Cheever, President of the Massachusetts Medical Society, J. R. Chadwick, Clarence J. Blake, and others.

ANTISEPSIS has done wonders in surgery, but in no department has its beneficial influence been more widely or more markedly felt than in the hands of the accoucheur. We all have painful recollection of Puerperal Septicaemia with its almost invariably fatal results in days gone by. But how changed is the position of the physician now. He no longer regards Puerperal Septicaemia as beyond the pale of curable diseases. We do not propose to enter upon a discussion of the cause and etiology of the disease in all its varieties or to show otherwise than incidentally how antiseptic or in other words cleanliness, as a prophylactic measure prevents, in the majority of cases of childbirth, the occurrence of septicaemia; that goes without saying. The particular procedure is of little consequence, the attainment of absolute cleanliness is the all important matter. Let us briefly state the principal points that must be observed. Before confinement the hands and nails of the accoucheur should be thoroughly cleansed and disinfected, or, if previously exposed to sepsis in any form, a bath and change of all clothing will be required. After confinement the uterus is to be thoroughly emptied, the patient's external parts to be scrupulously cleansed. Antiseptic napkins should be applied and changed reasonably often. From the second day on for two or three weeks an antiseptic vaginal douche is to be given at least once daily. This as a precautionary measure is, we know, neglected by many and even condemned by some high authorities, but we favor its use whenever a reasonably skilled nurse is obtainable, as we find it soothing and grateful to the patient, and we believe it favors involution of the uterus. Where such measures are observed the necessity for the intra uterine douche does not often arise, and though we agree with Lusk when he says, "in a rightly conducted confinement infection does not begin in the uterine cavity and hence the need of such injection is a confession of faulty procedure," yet we know, nevertheless, that in a large number of cases infection does so begin, especially in patients under the care of ignorant midwives. The doctor is usually called in when well marked symptoms are developed, such as high fever diarrhoea, rigors, thready and rapid pulse, sometimes delirium, clammy perspirations, a tender and tympanitic abdomen, fetor on fingers withdrawn from the os uteri. Formerly as we have said, these cases would be regarded as almost hopeless, but the intra-uterine douche will often effect a change little short of the marvellous. Nor are there any but the very simp-

lest appliances needed. After a thorough cleansing of the vagina with carbolyzed hot water, a Sim's speculum is used to bring the os uteri within easy reach and view; then we employ a large sized gum elastic catheter attached by means of rubber tubing to an ordinary syringe or to a fountain syringe, first filled to exclude air; the catheter is carried up to the fundus and the cavity douched till the water returns clear. We use 1-3000 corrosive sublimate for this purpose and are in the habit of following this with plain hot water to guard against the slightest risk of poisoning by residuum not expelled by the uterus. As to the question of frequency of repetition of the douche, we think the temperature is the most reliable index. On the return of high temperature, no matter whether in two days or two hours, let the same procedure be adopted. We may say that of late, if high temperature shows tendency to recur within twelve hours we have used the blunt curette, and our experience though limited has been most satisfactory. Nor is there any risk or difficulty in its use, as in all cases requiring this simple manipulation the os is patulous and the cavity can be reached without the least difficulty. We invite our readers to a discussion and an interchange of experience and opinions, upon this very interesting subject.

WE are glad to see that measures are being taken to obtain a Medical Act for P. E. Island. We wish our Island confreres every success in this step and we think we need not attempt to indicate the evident desiderata that will result from its accomplishment. The Profession will be benefitted by a worthy standard of medical education henceforth waving over the gates of entrance. Untrained pretenders will find the way debarred, and if hereafter they soil the courts and honor of the Profession they must do so as offenders against the law.

The public will benefit because they will be protected from ignorant and crafty forgeries, who are clever enough to deceive the commune vulgus, but who will now be detected and obliterated by the experts who, under legal sanction will scrutinize their genuineness.

Most of the Provincial acts with which we are acquainted we regard as defective, though considering the time and circumstances of their establishment, the framers thereof are not to be blamed.

We may refer, for instance, to the requirement of a double course of didactic lectures in nearly all

subjects. This being so the colleges must follow suit and in certain years almost all the students' time and energies are spent in the didactic class room.

We would like to see one course of *didactic* lectures recognized as sufficient in Anatomy, Physiology, Materia Medica, Chemistry, Midwifery, and Surgery. In Anatomy there should be required, in addition to dissecting, a course of Anatomical Demonstrations, and this might be accepted as an alternative for a second didactic course.

One course each of Physiology, Materia Medica, and Chemistry we consider sufficient if supplemented by proper Histological, Pharmacal, and practical classes.

One course of Midwifery and Gynecology is sufficient, but should be supplemented by more practical work than at present, so that twelve or twenty confinement cases (instead of six,) together with evidence of some practical gynecological experience might be accepted as an alternative for a second didactic course.

In surgery more practical work should be enforced. A course in operative surgery, the use of splints, &c., might properly be accepted instead of a second didactic course.

The Provincial Boards must lead the way in this matter; then the colleges can follow.

We think few having a knowledge of both systems would favour the American duplicate system with thereby necessarily limited practical work as compared with the British system under which a student can keep up with his classes in his reading as he goes on and at the same time be instructed in a very complete series of practical classes and practical clinical work.

The result of the non-requirement of the second courses will be that the time saved therefrom will enable the practical element of medical teaching to be much more developed to the undoubted advantage of both practitioner and patient.

**A**TENTION is drawn in our correspondence columns to the pursuance of an apparently arbitrary course on the part of the Department of Marine in cutting down medical accounts which contains a strictly fair valuation of services rendered. Such action is annoying, and when repeated is certainly an injustice.

The Minister of Marine is, we take it, the responsible man for his department, even for measures adopted by his Deputy Minister, whom our correspondent designates as immediately responsible in the precise instance named.

The government should obviously not shrink from paying according to a scale of charges which itself sanctions as legitimate and fair.

And for the government, through its officials, to dictate as it were, before hand, the precise amount of medical attention to be allowed and paid for in the case of any invalids would be to assume a position which we cannot imagine a responsible minister would, after enlightenment, wish or attempt to maintain.

We believe that a written statement of the hitherto grievances, signed by a few medical men and submitted to the responsible head of the department through the medium, it might be, of a parliamentary representative, would lead to a more equitable consideration of accounts for medical services.

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### *Reviews and Book Notices.*

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**HAND-BOOK OF MATERIA MEDICA, PHARMACY, AND THERAPEUTICS.**—Compiled for the use of Students preparing for examination. By Cuthbert Bowen, M.D., B.A., Editor of Notes on Practice. F. A. Davis, Publisher, Philadelphia and London, 1889.

Dr. Bowen has succeeded in making an excellent compilation of the essential facts of Materia Medica and Therapeutics. The form of question-and-answer book has been adopted for bringing out points. This has been in the main very well done. The preliminary sections of the book are excellent, particularly that on prescription writing, which is not dwelt on fully in any of the recognized text books. Woods' classification has been adopted, and nearly all the recently introduced drugs are referred to.

The work is designed to supply the needs of students preparing for examination, and would be of considerable service to busy practitioners desirous of reviewing their knowledge of the subject. Under forms of administration a large selection of combinations devised by recent authorities are given.

**THE INTERNATIONAL POCKET MEDICAL FORMULARY.**—With an appendix containing Posological Table; Formulæ for Inhalations, Suppositories, Nasal Douches, Eye-Washes and Gargles, Hypodermic Formulæ, Table of Hypodermic Medication, Use of Thermometer, Poisons and their antidotes, Post Mortem and Medico Legal Examinations, Artificial Respiration, Ligation of Arteries, Obstetrical Table, Urine Analysis, &c., &c. By C. Sumner Witherstine, M. S., M. D. Philadelphia; F. A. Davis, (price \$2.00.)

"The want of the present is crystallized knowledge. Names and doses of remedies, old and new, are in themselves insufficient. The busy practitioner, the recent graduate, and the earnest student must needs know how best to exhibit them, and how and when to give them. To this end the compiler presents the newer remedies in combination, with a large number of the older "time tried" formulæ of the best known practitioners at home and abroad."

We are quite ready to admit the 'point' of the above quotation from the introduction to this first-rate pocket book. It is a fact that many of the really valuable newer remedies are not used because of an unfamiliarity with a precise and proper mode of prescribing them. Did it contain nothing else the prescribed combinations, (embracing the newer as well as older drugs,) for all the more important diseased conditions, (alphabetically arranged,) would make the Formulary a practically valuable addition to the table or the pocket.

No less than 1658 Formulæ are given, all accompanied by

the names of the prescribers, among whom are included many eminent authorities.

To the directions following each prescription are often added special indications of the precise form or stage of the disease for which they are indicated, or of the age of the patient, &c., for which they are suitable. Few, if any, diseases or drugs of importance are omitted.

An appendix contains concise notes upon the subjects mentioned above, and being so quickly and conveniently available will be found of frequent use.

We recommend this little book to the busy practitioner and to all who have found a difficulty in putting into concrete prescriptions the general knowledge they have gathered of the therapeutic value of many new and useful drugs.

Though we must not be understood to encourage a lethargic inability to diagnose and treat a case without a reference to a hand-book.

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### Notes and Comments.

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THE *Canadian Practitioner* thinks it unjust to compel the students to attend the same course of didactic lectures twice. Amen.—*American Lancet*. Amen.—M. M. NEWS.

THE commissioners appointed by the Belgium Academy of Medicine, have come to the conclusion that saccharin cannot be considered a substitute for sugar in aliments.

ELSEWHERE will be found an announcement of the Halifax Infirmary. Such an institution meets a frequent want. On the one hand, it enables patients to undergo surgical treatment with the desirable accompaniment of careful and experienced nursing, and in the possession of various advantages lacking in a private house.

On the other hand, doctors who have not at hand proper facilities for employing serious operative procedures will appreciate their ability to recommend their patients to such an institution. The names of the gentlemen on the staff may be considered a guarantee that the institution will be conducted on strictly professional and scientific principles.

THE Commissioners have decided to build a new wing to the St. John Hospital, applications for admission being frequently more numerous than the beds at their disposal. This has been more especially the case with regard to patients requiring private rooms. It is expected that in the new building increased facilities will be given for cases requiring abdominal section, and others in which it is essential that perfect asepticism should be maintained.

WE do not know of any drug of the many used for chronic bronchitis, bronchial catarrh and kindred conditions, that has its efficiency vouched for more strongly than Terebene. Brought into prominence by Dr. William Murrell, of London, who, after carefully testing, came to *rely* upon its special curative powers in the class of cases mentioned, it still retains the confidence and receives the recommendation of that experienced Therapeutist.

The value of the drug is attested by many eminent physicians and as the result of the now prolonged experience of capable men Terebene is removed from the catalogue of "new remedies," and deserves its place on the list of reliable drugs. It does not appear to have been used very commonly in this country, but we have no doubt that it will win its way into frequent use.

Terebene is a powerful expectorant and is antiseptic. It exerts a curative influence on the bronchial catarrh; it relieves dyspnoea; it purifies and lessens the discharge in bronchorrhea; and may be used with benefit in most chronic catarrhal

conditions of the mucous membranes, but especially of the bronchial. In the *New York Medical Journal*, Dr. Suckling is quoted as reporting a hundred cases in the Birmingham Workhouse Infirmary, (ninety-four of chronic bronchitis, and six of phthisis) treated by Terebene. Seventy-two per cent. of all the cases were relieved, many of them greatly so. Dr. Suckling gave five drop doses every four hours, increasing in a couple of days to ten drops. These figures are a fair representation of the value of Terebene. Many series of cases equally favourable in their results might be collected.

Most of the above patients were well advanced in years. This being kept in view, the age of the patients and the peculiarly intractable nature of the conventional "winter cough" of middle aged and elderly people, the conclusion is justified that Terebene merits that its powers should be more commonly taken advantage of.

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### Selections.

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#### SULFONAL.

DR. MATHES, in the "Centralblatt für Clinische Medicin," says of this drug:—He has administered sulfonal in cases of tuberculosis and cardiac disease, in meningitis, in alcoholic delirium, anaemia, infectious fevers, cirrhosis, tabes dorsalis, neuralgia, &c. In short, he has tried the fashionable remedy in all cases which came under his notice without distinction. This way of proceeding need not be condemned, for it has shown the harmlessness of sulfonal, in certain doses, in all the cases experimented upon. It is worth knowing for example, that cases of cardiac disorder stand without inconvenience the same quantity of the drug as the cases of Phthisis; one cannot say as much of chloral. There follows from such statistics the general deduction, that sulfonal has complete hypnotic effect in 72 per cent. of all cases; an incomplete effect in 9.25 per cent., and is inefficacious in 18 per cent.; that in 19 per cent. it produces accessory manifestations; finally, that in most cases it acts better the second night than the first, which fact, if confirmed, shows a marked superiority over morphine and the derivatives of opium in general.

In what do the accessory manifestations consist? Simply in buzzing of the ears, slight headache, deafness, general fatigue, and exceptionally in vomiting. But on the other hand, we do not observe cardiac or respiratory disorders or modifications of the appetite or digestion. It is, we see, almost the perfection of an hypnotic, if we take account of the fact that these phenomena are very rare.

The following are the author's conclusions:—

I.—Sulfonal is a useful hypnotic, although it may not be always efficacious.

II.—It has the advantage over other hypnotic agents, of possessing neither odor nor taste, of exercising no influence over the essential vital organs.

III.—It causes no bad effects, except in a very small number of cases, and in these the worst it does is generally insignificant.

IV.—The dose is variable, and depends upon the susceptibility of the individual. Most generally one gram. (about gr. xv.) is sufficient to produce sleep, without accessory manifestations. When those appear it is only necessary to diminish the dose.

V.—On account of the slowness of the action of the medicine it is well to administer it at least an hour before going to bed.

VI.—When insomnia is due to an irritating cough, or to pains not clearly neuralgic, the use of sulfonal is contraindicated. In most of the true neuralgias, on the other hand, it appears to be of benefit.

We may notice in passing, that M. Mathes shares the opinion of Salgo, relative to the slight sedative effect of sulfonal in mania and delirium. Dr. Garnier, Director of the Lunatic Asylum La Charité, thinks that sulfonal appears to have an assured future in the therapeutics of insanity. This appreciation, agreeing with that of Rabbas, (of Marburg), evidently does not undervalue the hypnotic effect of this new medication. Rosenbach, Rosin, Ostreicher, Crämer, Schwalbe, Kast, Schney, Fraenkel, confirm, from the results of their personal experience, the preceding facts: They proclaim the remarkable efficacy of sulfonal as producing artificial sleep absolutely comparable to natural slumber. This sleep, after the absorption of a dose of two or three grams, lasts usually five or six hours, without the least modification of the pulse or respiration. They declare the drug superior to chloral, paraldehyde and all others, except for its high price.—*Am. Journal of Insanity, Jan'y, '89.*

**BEEF TEA.**—Recently we have more than once noticed that doubt has been expressed as to the efficiency and value of the much used, time honored *beef tea*.

In the *British Medical Journal*, Jan. 26th, Mr. Thomas Laffan impartially gives his views in this connection. Mr. Laffan represents Liebig as stating "that the greatest care is taken to exclude from his extract all fibrine, gelatine, albumen and fat." That "to extractives and salts is due all the value it possesses; that it is to be classed with tea and coffee." As to the difference between ordinary beef tea and his (Liebig's) extract of meat he merely claims for the latter that it contains less water than the former.

Another standard authority, M. Sée, holds in the main, similar views as to the deficiency in beef tea of albumen, carbo-hydrates and fats. Further M. Sée admits that if with a convalescent the strongest beef tea should replace milk the result would be disastrous.

The names of Hassall, Sibson, Wilberforce, Smith, Brunton, Masterman and others, may be cited in support of like views.

Dr. Hassall long ago showed that 14½ lbs. of beef would be required to yield beef tea enough to supply the nitrogenous daily waste of one individual, calculating that such waste amounts to 412 grains of urea and 21 of uric acid daily.

The following is an analysis of a sample of 'conventional' beef tea made from rump beef, 2 lbs. of meat to 2 pints, macerating it for four hours and then simmering it for six. No strainer was used, but the meat debris was excluded. The resultant was clear:—

Water.....	98.48
Albuminates and crystalline bodies, kreatine, &c..	.90
Fats.....	.07
Salts.....	.55

Now taking the analysis of Hassall, who found only 22.10 grains of nitrogen in each pint of beef tea, (1 lb. to the pint), made under the boiling, and 41.10 grains in that made under the infusing process, and the further opinions of Sée and Liebig, it is quite plain that we have in beef tea properly prepared, no value whatever commensurate with the cost, and an insignificant nutriment for the sick.

If beef tea then, afford us such small aid, let us see what aids we can summon for the sustenance of the patient who is

temporarily incapacitated from using the ordinary solid meat.

The first and chief resource seems to me to be milk, the richness of which in albumen fat, sugar, and salts, mark it out as pre-eminently suited for the supply of the necessary nutriment during what we shall call the interregnum. The digestive weakness which hinders the use of solid meat is a mere approximation or return to that of the infantile state. We know that the wants of this are fully supplied by milk, we know also that this is the only nutriment with which its powers are able to cope.

The next substitute for the system of alimentation by beef tea is that with which Trousseau's name is associated. It is that of minced raw meat. When we find this successfully employed in conditions of the system in which superficial ulceration of the intestinal mucous membrane constitutes the essential feature, and when that membrane is still more acutely inflamed, as in the infantile cholera of summer, it is hard to set limits to the cases to which its employment may not be applied.

Lastly we have rectal alimentation to supplement any deficiencies of mere fluid ingesta. The late Dr. Peaslee, of New York, for five and twenty years employed this system in many cases of acute inflammation, when solid food was inadmissible by the mouth. At first he employed beef tea, but losing all confidence in it, he soon abandoned it for Leube's pancreatic emulsion which he administered in quantities of 3 or 4 ounces every three or four hours.

The late Dr. Flint, of New York, in a paper read before the New York Academy of Medicine, quoted several cases where life had been sustained for a long period by this method alone. In one of these cases life was maintained for fifteen months, and in another for five years, almost entirely on it.

#### MENTAL DISEASES SUBSEQUENT TO GYNÆCOLOGICAL OPERATIONS.

WERTH, (Arch. für Gynäk) in a paper read before the German Gynecological Society, reported six cases of mental disease observed after three hundred gynecological operations.

Three of the cases occurred after total extirpation of the uterus; the other three followed operations where the ovaries and fallopian tubes were removed. In five of these cases the patients showed symptoms of mental depression, amounting in one case to a severe attack of acute melancholia. Four of the six patients recovered rapidly, the other two remained mentally unsound. Dr. Werth referred to twenty-four recorded cases of insanity which had followed gynecological operations.—*Medical Chronicle.*

#### BRAINS OF DEAF MUTES.

J. WALDSMIDT ("Allgemeine Zeitschrift für Psychiatrie," xlii Band, 4 Heft) describes two brains of born deaf mutes: One was a man of 46 years, the other a girl of 19. Neither of them seemed to have received much instruction, and both were of low intelligence. The two brains had this peculiarity in common, that the third convolution and island of Reil were less developed on the left side than on the right. This is made clear by some lithographed plates, in which the left island is compared with the right, and with figures from a normal brain. The temporo-sphenoidal gyri were well developed on both sides in the male. In the female brain the third temporal gyrus is scarcely recognizable.—*Journal Mental Science, Jan'y, 89.*

**SHOCK CAUSED BY SURGICAL OPERATIONS.**—Mr. Christopher Heath, F. R. C. S., pleads for greater rapidity in getting through with surgical operations, as much so as is consistent with carefulness. He fears that many patients suffer from shock because of the too long exposure to the unaccustomed surroundings of the operating table, the nakedness of the skin and flesh, the manipulations of the operator, the anaesthetic, loss of blood, &c. He quotes Dr. David Cheever, of Boston: "Do we realize what this prolonged cutting, pinching, and dissecting means to the nervous system after anaesthesia is past."

In feeble subjects the lack of nourishment which precedes an operation, desirable on account of safe anaesthesia, is much aggravated by their inability to retain food after the operation. This has an important influence in bringing about collapse. Lowering of the bodily temperature is constant after an operation under anaesthesia. The thermometer frequently falls to 97° and 96°, and, after severe and prolonged operations, to 95° F. This is a very serious matter, and has a marked influence in delaying re-action from shock.

This chilling of the vital heat is induced first by anaesthesia, which, if prolonged, ends in a dripping sweat; next, by careless exposure during an operation. Then also it is largely due to antiseptic irrigations, to vapour douches of similar agents, to applications of cloths wet in corrosive or carbolic solutions around the site of the operation.

In order to guard against the shock of large operations, on weakly patients, Mr. Heath has, for some years now, adopted the procedure of injecting into the rectum with a long tube, two ounces of brandy with four of hot water, half an hour before the operation. This acts as a reserve of power which can be absorbed at leisure. The injection can be repeated during the operation if necessary, and may be combined with the subcutaneous injection of ether.

Mr. Heath also strongly advises the subcutaneous injection of gr.  $\frac{1}{4}$  to gr.  $\frac{1}{2}$  of morphine, combined with gr.  $\frac{1}{16}$  of atropine before the patient leaves the table, believing that not only is pain thus relieved, but that sickness is materially kept in check by the combination of drugs.

*British Medical Journal.*

PROF. A. L. LOOMIS in a lecture on the *treatment of acute lobar pneumonia* last week, recommended the following: Counteract the shock of the first few days with opium (morphine hypodermically); keep the temperature down with quinine; when the heart begins to fail, *and not before*, use your stimulants, giving brandy at first. If this fails, sustain the heart and carry it past the crisis with citrate of caffeine, in five grain doses every five or six hours. It acts on the nervous system rather than on the heart muscle itself, and is not diuretic. Digitalis he thought contraindicated in an uncomplicated case, and convallaria and strophanthus too unreliable for use. If pulmonary oedema comes on, relieve it with dry cups. Calomel, to unload the portal system, is dangerous because of its depressing effects. Counter-irritants are also bad, and he uses instead the flannel and oil-silk jacket or a hot mush or flax-seed poultice that completely encircles the thorax. This should be applied as hot as can be borne every two hours, and will give much better satisfaction than a poultice over only a portion of the lung. Expectorants are of no service unless the mucus is very tenacious, when small doses of the muriate of ammonia can be given. Large doses are contraindicated, as they upset the stomach, while as a heart stimulant the drug is inferior

to champagne. The use of cold is likely to do harm. To this treatment he adds absolute rest, a diet of milk, eggs, broth, etc., and uses the ordinary remedies for cough and other symptoms that may arise.—*Medical and Surgical Rep.*

#### RESULTS OF REMOVAL OF THE THYMUS.

DR. AWTOKRATOFF, in a communication given to the Psychiatric Society of St. Petersburg, ("Neurologisches Centralblatt," No. 24, 1887,) detailed some experiments upon removal of the thymus gland. Of twelve dogs only one survived the operation for any length of time. Most of them died in nine or ten days—one in sixteen days—after the operation. Two or three days after the removal of the gland there was a remarkable dullness and slowness in their movement, and a peculiar alteration in their gait. After this came on tremblings, which began in the hind legs and spread gradually over the whole body. The temporal muscles and the tongue were most affected. The tremblings were gradually succeeded by clonic and tonic convulsions. Some of the dogs had epileptoid attacks, and died in the status epilepticus. There was also diminution of the bodily weight, while the temperature remained normal. There was considerable increase of the galvanic excitability in the peripheral nerves, and in two dogs there was found to be an increase in the electrical irritability of the motor centres in the brain.

In several cases there was acute catarrhal conjunctivitis.

From the time which elapsed till the appearance of the convulsions, the author supposes that a poisonous substance is produced in the organism by the removal of the thymus gland, which has a cumulative action.—*Journal of Insanity, Jan'y, '89.*

*The relative value of Opium, Morphine and Codeine in Diabetes Mellitus.* Prof. T. R. Fraser, of Edinburgh University, than whom we cannot name a more trustworthy authority on Pharmacology and Therapeutics, carefully observed the effects of the above drugs in diabetic cases. The results were read before the Glasgow meeting of the B. M. A. Association, and are recorded in a late number of the journal. He concludes:

"A consideration of these averages seems to show that under a daily administration of one grain of hydro-chlorate of morphine, the quantity of fluids drunk, and of urine, urea, and sugar voided, was rather less than when three grains of opium, and decidedly less than when fifteen grains of codeine were being taken. In three other cases in which I have instituted a comparison between these substances in diabetes mellitus, morphine also showed a marked though not so great superiority over codeine."

"After this note had been prepared I have seen a recent paper by Dr. Bruce, of London, in which similar results were obtained in two very carefully observed cases. So far as I know also, the favour with which codeine is regarded in this disease, has not been supported by any observations calculated to show its value relatively to opium or morphine so clearly as in the cases to which I have referred. The evidence therefore, seems to indicate that codeine is a less powerful remedy in diabetes than either opium or morphine, and to confirm the view that in its therapeutic value it ranks as a weak or diluted morphine. The conclusion receives an importance (no doubt a subsidiary one) from the circumstance that codeine is about three times as expensive a substance as morphine. When we consider the large doses that are

required in diabetes mellitus, and the generally protracted duration of this disease, we are, I think, justified in asking for more clear evidence of its superiority over morphine than has as yet been produced."

In a recent paper by Professor Gerhardt in the Medical Press and Circular, noticed editorially in the Medical Record are included the following statements and views concerning the diagnosis and treatment of ulcer of the stomach.

He states that bleeding occurs in only forty-seven per cent.—much less frequently than according to the usually quoted statistics.

On the absence of any palpable tumor, as an important negative symptom of gastric ulcer, Prof. Gerhardt places little reliance. He mentions four kinds of tumors that may be associated with gastric ulcer, namely, 1. Old ulcers with indurated margins; 2. Pyloric muscular thickening; 3. Circumscribed exudation around perforations (very rare form), and, 4. A tumor caused by the crowding of neighbouring organs into a large gastric ulcer.

With reference to the commonly asserted hyperacidity of gastric juice in cases of gastric ulcer, Prof. Gerhardt has lately, in twenty-four cases found the reaction normal in seventeen cases, not so in seven.

He concludes that in some cases of ulcer, the increase of hydrochloric acid is wanting. Given a disease of the stomach lasting three years without formation of a tumor and we are justified in assuming the probability of an ulcer.

The seat may generally be determined by the situation of the pain which is rarely absent in fresh ulcers.

When a patient abstains from food because of pain in the stomach, and becomes thin and reduced in consequence, the disease is more probably ulcer, hardly carcinoma, rarely nervous dyspepsia. Emaciation is often seen in old cases, but rarely so in the case of recent ulcer. Ascertaining the weight of patients is important diagnostically.

The duration of the ulcer was sometimes as long as twenty-five to thirty years with intervals of good health intervening.

As to treatment.—Milk diet often suffices in recent cases, but in the case of old ulcers with structural changes is often not well borne.

The diet most to be recommended was one mainly animal; meat, milk and eggs.

FOLLOWING the example of some of his countrymen, especially M. G. See, Dr. Fanchou has tried the effect of subcutaneous injection of antipyrin and cocaine in labour. The following solution was injected into the tissues of the abdominal wall:—

Antipyrin . . . . .	Grammes 2.00
Chlorhydrate of Cocaine . . . . .	" 0.04
Distilled water . . . . .	" 4.00

The result in three cases in which the method was adopted was that labour pains were lessened, the patient became patient and calm, the cries of the patient ceased, and labour terminated with no attendant pain. Nothing is said about the action of the drug on the dilation of the cervix uteri.—*British Gynaecological Journal.*

THE CAUSE OF HEAD DOWNWARD PRESENTATION.—By James Foulis, M. D., F. R. C. P., Edin. In an article on the "Cause of Head Downward Presentations in Pregnancy," the author concludes that the head downwards position of

the child in utero is the necessary and ultimate consequence of the continued extension of the child's lower limbs against the most resisting parts of the uterine sac. The first cranial position of the child's head is the necessary and ultimate consequence of the continued extension of the child's lower limbs against the most resisting part of the uterine sac in its upper part, viz., that which lies in the right hypochondrium, after the child has assumed the head downward position.—*The British Gynaecological Journal.*

### Obituary.

It was with great surprise and regret that we received the intelligence of the sudden death of the late Dr. J. Simpson Lathern.

After receiving his medical education at McGill University, and taking the license of the Royal College of Physicians, London, Dr. Lathern settled in Halifax. He soon came to hold various important professional appointments, and had laid the foundation of a successful career. In their untimely loss his family have the deep sympathy of the late Dr.'s professional brethren.

### Personal.

DR. A. F. EMERY has resigned his position as Resident Physician and Superintendent of the General Public Hospital at St. John, and has gone to New York where he has become associated in practice with a physician who does a large and lucrative business.

DR. F. S. KENNEY, a graduate of McGill University, and who took a good position at college, has been appointed to the vacancy. Before Dr. Emery left the visiting staff of the Hospital unanimously adopted the following resolution, which speaks for itself:—

*Resolved,* That the medical staff desire to express to Dr. A. F. Emery, house surgeon, on his departure, their entire satisfaction with his work during his residence of two years in the institution. His care of the patients and attention to his duties have been most commendable. They offer him their warmest wishes for his future success.

### Books and Pamphlets Received.

HAND BOOK OF MATERIA MEDICA, PHARMACY AND THERAPEUTICS.—By Cuthbert Bowen, M. D., B. A. Philadelphia; F. A. Davis, 1231 Filbert St. Price \$1.40 net.

THE INTERNATIONAL POCKET MEDICAL FORMULARY.—By C. Sumner Witherstine, M. S., M. D. Philadelphia; F. A. Davis, 1888. Price \$2.00 net.

PULMONARY CONSUMPTION CONSIDERED AS A NEUROSIS.—Being two of a series of evening lectures given at the Philadelphia Polyclinic in the course of 1888 and 1889. By Thos. J. Mays, M. D., Professor of Diseases of the Chest in the Philadelphia Polyclinic. Publisher, George S. Davis, Detroit, Mich.

THE CORTICAL LOCALIZATION OF THE CUTANEOUS SENSATIONS.—By Charles L. Dana, A. M., M. D., of New York.

CONTRIBUTIONS TO THE ANATOMY AND PATHOLOGY OF THE THYMUS GLAND.—By A. Jacobi, M. D., Clinical Professor of the Diseases of Children in the College of Physicians and Surgeons, New York; President of the New York Academy of Medicine.

OSTEOTOMY FOR ANTERIOR CURVES OF THE LEG.—By De Forest Willard, M. D., Lecturer on Orthopaedic Surgery, University of Pennsylvania, etc.

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(Signed)

MORRIS H. HENRY.

To Mr. N. D. ARNOLD.

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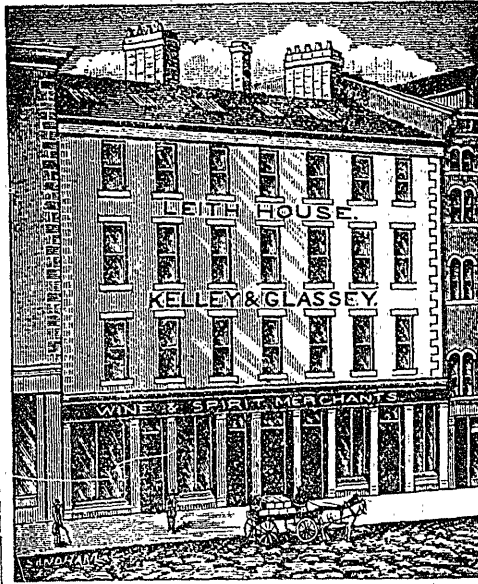
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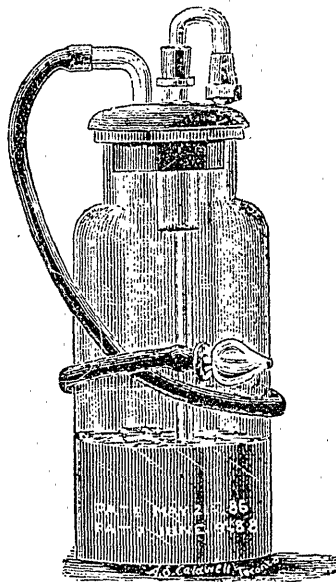
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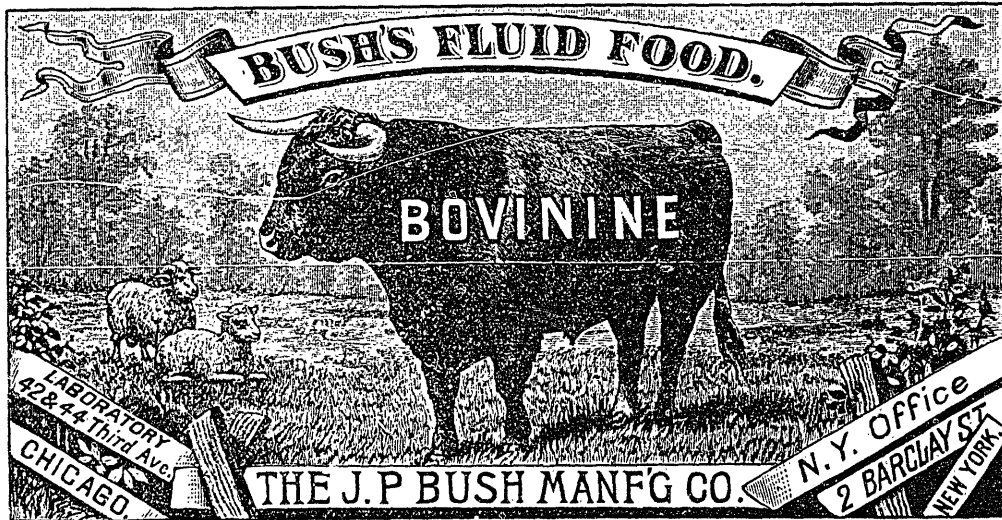
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Now, as to the pepsin question. What pepsin do you prescribe, and why? If you will examine the facts we present, you can have only one opinion as to pepsin in future. Circulars fully presenting the claims we make for our scale pepsin, with a sample of it, will be mailed to physicians who wish to investigate it.

We can only say here that in appearance, solubility, digestive strength and permanence, it is far superior, and admittedly so, to any pepsin hitherto introduced.

A careful search through the prescription file of a prominent New York pharmacist reveals the surprising fact that fully 75 per cent of physicians neglect to specify when prescribing pepsin, but simply order "pure pepsin." Now they might as consistently order "solution of cocaine," without designating any particular strength.

"Pure pepsin," as it is known commercially, is not a definite principle; neither has the Pharmacopœa as yet established a standard of strength, and consequently every producer is a law unto himself. It is obvious that digestive activity is the sole criterion of therapeutic value in preparations of the proteolytic ferment, and a physician is consequently enabled to predict with reasonable certainty the comparative effect that may be expected from the various pepsins found in the market.

The following tabulated statement of the comparative quantities that should be prescribed in order to accomplish the same purpose, may, therefore, enable them so to write their prescriptions that the best shall be obtained at the lowest price.

These figures are based on each manufacturer's claim, without regard to the discrepancies that we know to exist; but when the fact is considered that our Pepsinum Purum in Lamellis, with a digestive power of one to 2000 is marketed at a price comparing favorably with that established for many of the inferior varieties, the economy of its employment becomes patent. If it is desired to administer sufficient of the ferment to dissolve 1000 grs. of albumen, obviously  $\frac{1}{2}$  gr. of the aforementioned pepsin will be sufficient. To derive the same therapeutic effect from one for which the manufacturer claims a power of 1200,  $\frac{1}{10}$  gr. will be necessary. A power of 1000, 1 gr.; a power of 900,  $1\frac{1}{10}$  gr.; a power of 700,  $1\frac{1}{2}$  gr.; a power of 500, 2 grs.; a power of 150,  $6\frac{2}{3}$  grs., while a power of 50 (which is the standard adopted by our Pharmacopœia), 20 grs. will be necessary.

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