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## Original Communications.

### GYNECOLOGY IN GENERAL PRACTICE.

By A LAPHORN SMITH, B. A., M. D., Gynecologist to the Montreal Dispensary, Surgeon to the Women's Hospital, Montreal.

This important department of medicine has made such wonderful and rapid progress and has extended its domain indirectly so much in the human body that the general practitioner must have great difficulty in keeping up with its advances. No sooner is one book out than another is announced to appear, and when it is purchased, a method of treatment in the first is considerably altered and modified in the second. I purpose, therefore, to write a paper on this subject which I hope will contain some useful information, and especially, which shall be up to date. A great many of the most important cases which come into the hands of the specialists might be just as well attended by the family physician, if he but recognized them in the earliest stages, while many others which require the most anxious attention of the specialist might be easily attended to and cured if they had been sent to him sooner. A great many of the diseases from which women suffer began as simple congestion while they were girls, and were due to well-

known and remediable causes, such as, for instance, chronic inflammation and benign tumors of the uterus, tubes and ovaries. This congestion is sometimes passive in its nature, due to mechanical obstruction of the pelvic circulation; which obstruction may have been located in a tight corset pressing upon the inferior vena cava which receives the blood from the pelvis, or it may be due to the tight corset pressing the liver against the main venous trunk, and thus impeding the return of blood to the heart, or the obstruction may be due to overloaded intestines pressing upon the delicate veins which carry the blood from the pelvis into the common iliac veins. All these causes are, of course, remediable, and yet the majority of patients with diseases of the pelvic organs come under my care with these causes operating in full force, and it is my first duty, if I wish to treat them rationally, to remove the causes before attempting to remove the effects. It is hardly credible, but it is my daily experience, both at my clinic and at my office, to have patients reply that their bowels are regular every week or every ten days. Many women consider the question somewhat impertinent, and answer that their bowels are regular when they are not so, either wilfully or from motives of delicacy; but I can give my word for this, that we cannot expect to

make any progress with these cases until we have secured a regular evacuation every day. The corset is an obstruction which has been sanctioned by many years' custom, and which women wear only to satisfy the demand of silly men who admire a small waist, so that it never will be given up until men who are about to marry shall have been taught that a tight corset means a sick wife.

Many of the diseases which come to me in an advanced stage, would readily have been detected by bimanual examination if it had been made. This brings up the question of which cases should a general practitioner examine, and which should he not. In the diseases of girls before marriage it is rare that a digital examination is required. The appearance of these patients alone is almost sufficient to make a diagnosis: and a few supplementary questions, if truthfully answered, places it almost beyond a doubt. For this reason, it is better to instruct the mother to obtain the exact information on those points for us. The appearance of the girl's face, the color of her lips, the fact that her periods are scanty and pale in color, and that during the intermenstrual periods, she has a profuse discharge, tells us at once that she is suffering from anæmia. In that case, six weeks or two months of the administration of one or two of Bland's pills, three times a day before meals, will bring the color to her cheeks, arrest the leucorrhœa and make her periods more natural in quantity and quality. If, however, she is suffering from constipation, as nearly all of them are, this will not be sufficient, for in addition to the scantiness of the flow, you will find that she suffers pain with it due to congestion. In that case you must combine aloes with the iron, such as the pill ferri et aloes, one three times a day after meals, more or less according to the condition of the bowels. If the congestion is very great and the nervous system is in a weakened state, then a mixture containing 10 minims. of phosphoric acid, 10 of tincture of iron, and 10 of tincture

of nux vomica for each dose may be used to improve the appetite and tone up the circulation. But as this mixture is not laxative, some mild purgative must be given in conjunction with it until by regular habits the patient has acquired the ability to evacuate the bowels without medicinal aid. The occupation and habits of women, and especially of young women and school girls, deprives them of two important auxiliaries, namely, sunshine and fresh air. Unfortunately, there is no drug which can replace these necessaries of life, so that the physician is justified in sacrificing studies, which after all are of secondary importance, in order that his patient may grow up robust. Too much education has a great deal to answer for in producing sickly girls and still more sickly wives.

When an examination of the pelvis is absolutely needed in young girls in order to determine the existence or absence of a pelvic tumor or a displacement of the uterus, then the rectum should be used for this purpose, as it is a serious matter even for a physician to commit what has been called a moral rape, if it can be avoided. In married women, of course, this does not hold true, for they generally know a good deal about their uterus and ovaries, and there is not the same danger of causing them to have what another authority has called, ovarics on the brain.

When an examination of the pelvis is necessary, it should be made thoroughly, and this cannot be done with the patient lying in the hollow of a bed. If possible, she should be induced to come to the office where an examination table or chair can be used. For that purpose, a common pine table such as is used in a kitchen, answers every need. It may be covered with a cushion or a folded blanket, and have a pillow for the head, but it is absolutely necessary that *it should be short*, so short that the patient will be compelled to make the pelvis project over the lower end, as a thorough examination cannot be made if she shrinks from you half way up the

table. For this reason it would be well to fix a piece of board across the top of it so that she could not get her head beyond the other end. The feet may hang from the end of the table and rest upon two chairs, or better still, a hardwood foot rest can be easily added on each side, which can be slid out a distance of one and a half feet, to rest the feet on; but I repeat again, a thorough examination of the pelvis can only be made when the patient's pelvis projects over the edge of the table. Neither need you expect to make a thorough examination with one finger only. Many abnormal growths in the pelvis are moveable and slide away from the finger, and thus elude detection, but with the other hand press gently but firmly upon the abdomen just above the brim of the pelvis until it meets the internal finger, when nothing of consequence can be there that would escape your notice. Two fingers in the vagina give much more information than one, and you will be surprised to see how little difference it makes to the patient. You not only can get farther up with them, but may often gently catch the cervix between the two and lift the uterus up towards the outside hand, thus determining its size and position, as well as the presence of pregnancy and fibroid growths. After having noticed the condition of the uterus, slide your fingers into the posterior cul de sac of Douglas, where an ovary may be felt—you will know whether it is an ovary or not by the sickening feeling which the woman will express on the slightest pressure of it. On moving the fingers forwards again on either side of the uterus, with the outside hand still pressing the abdomen down, you will feel the slightest abnormality in the broad ligaments, as also enlargements of the tubes, whether from hydro, pyo or hæmato salpynx or tubal fetation. In making such an examination it is well to keep up a constant conversation with the patient in order to distract her attention and thus relax the abdominal walls. If you cannot thus relax them, or she cannot do so voluntarily, then no examination

is complete, especially in stout subjects, without an anæsthetic. You will sometimes feel with the internal fingers a rough and nodular condition of the cervix, if the patient is 45 or 50 years of age; if the meno-pause has come some years before, and if your examination, gently conducted, causes bleeding, then you may be on the look out for cancer of the uterus. Without causing bleeding, you may find the cervix nodular and enlarged, and in putting your finger before and behind it, you will be able to hook it on the anterior and posterior lips, each offering the form of a trumpet mouth; and on drawing the anterior and posterior lip together with the two fingers, you will find that they can be approximated. This is evidence of a lacerated cervix, with cystic degeneration, owing to the prolonged exposure of the cervical glands, which were never meant to be exposed at all. This rolling out and exposure of the cervical mucous membrane used to be considered and treated as ulceration of the neck. On introducing a cusco speculum the torn lips can be still further everted, and a stringy mucous may be seen extending up the canal. This is an evidence of endo-cervitis. Sometimes the lips of the cervix are enormously enlarged. In stabbing them to the depth of an eighth or a quarter of an inch an ounce or two of blood may be got to flow out of them. At the same time the diseased cysts are punctured and emptied of their acrid secretion. Tampons of cotton wool thoroughly saturated in glycerine containing 10 per cent. of boracic acid should be inserted by the aid of speculum and forceps three days a week for two months when all the redness and tenderness will have disappeared. The torn edges should then be united after the removal of the cicatricial tissue in the angle of the tear, according to Emmett's method. Let me now say a few words about the preparation of these tampons. Take a roll of absorbent cotton and divide it into 70 little cylinders a little longer than they are thick. Then tie a piece of linen thread eighteen inches long

around the centre of them, leaving the two ends about 8 inches long. When you have seventy of these tampons made dip them one by one into a pint of water containing 7 grains of sublimate, squeeze them out and hang them by the threads in a warm place free from dust to dry. Each tampon will then have one-tenth of a grain of bichloride. By coloring the liquid with aniline dye you will exactly know whether the tampons have been sublimated or not. These tampons are then packed rather firmly in gem jars or wide mouthed stoppered bottles and hot boroglyceride (10 parts of boracic acid diluted in 90 parts of glycerine) is poured over them until they are saturated. By applying one of these to the cervix 2 or 3 times a week and leaving it in for 48 hours congestion and tenderness of the pelvic organs may be immensely relieved in a month or six weeks. At the end of 48 hours the patient may withdraw it by the string left hanging from the vagina, and she may then give herself a vaginal douche two or three times a day before the next application. This matter of hot vaginal injections or douchings as it is called requires special directions. You tell a woman to syringe herself with hot water and what does she generally do? She will probably use a little two-dram glass ear syringe and perhaps refill it a few times, making in all about an ounce. I need hardly say that this is useless. To be effective douching must be performed as follows: The woman lies on a sofa or edge of the bed with a piece of oilcloth under her leading into a pail. The nozzle of the syringe is introduced backwards to the posterior vaginal fornix, and at least half a gallon of water as hot as the hand will bear is allowed to flow with some force. Care must be taken to plug up the centre hole of the nozzle as severe pain is sometimes caused by injecting water into the uterus. Unless specially instructed, women will generally take an injection while squatting over a basin; this method is inefficient, because the water runs out alongside of the syringe as fast as it

goes in without touching the uterus at all. As long as there is any acute inflammation, as evidenced by tenderness and heat, on digital examination and by the redness on passing the speculum, the cervix is not in a fit condition to be sewed. For this reason I have often been compelled to treat patients sent me from the country for three or four weeks before I could safely venture to sew up the lacerated cervix.

In cases of leucorrhœa not depending on anæmia or not improving under tonic iron treatment, the following I have found to rarely fail me:

Zinci sulph.

Plumbi acet., āā ʒj.

Mix and divide into four powders. Each powder to make one quart of injection. Use a teacupful as a vaginal injection three times a day.

In married women discharges of all kinds, not excepting gónorrhœa, will be speedily stopped by the application of a boroglyceride tampon every day or two. Even many cases in which there is a discharge of pus from the uterus are soon relieved by their use. In single women we had better depend upon injections.

Among other things which you may readily recognize by means of bimanual examination are the different abnormal positions and forms of the uterus. Only a few of these are of any importance; thus: the uterus may be very high up, to one side or the other side, or it may be anteverted without producing any bad symptoms. It is only when it is retroverted, prolapsed or sharply bent on itself that it requires treatment. All these conditions are due to relaxation of the muscular fibres which should hold it up with very often increased weight to the organ itself; our first duty, therefore, is to diminish its weight by boroglyceride tampons, removing obstruction to its circulation, and our next to tone the relaxed organ up with good food, good air and strychnine. But the most effective treatment where there are no adhesions is the coarse wire faradism with

slow interruptions, the two poles being introduced into the uterus or merely into the vagina. This sets up thousands of contractions in the muscular fibres of the uterus and its ligaments, and so to speak puts them through a series of gymnastics. I have had a great many cases of relaxed condition of the pelvic organs completely cured by this means. When the uterus is bound down with adhesions, faradism will of course be useless. In this case I am in the habit of doing one of two things: either to gradually stretch these adhesions with the above tampons, placing in two or three or more each time, and occasionally painting the vaginal roof with tr. iodine, or else making one or two constant galvanic applications with a ball electrode in the vagina. By this means I seldom fail to stretch and absorb the adhesions and to restore the uterus to its normal position. Or else I perform hysterorrhaphy (or sewing of the uterus to the abdominal wall) in the following manner: I carefully wash and scrub the abdomen with soap and sublimate solution; I then make an incision in the median line as near to the pubis as I can without risking the bladder. I then introduce one or two fingers of the left hand into the abdominal cavity and seize the fundus, tearing it away from the adhesions, while an assistant pushes it towards me with a stout rod in the vagina. When it has been quite freed I seize it with a pair of bullet forceps near the fundus and hand them to another assistant to hold. I then with my scalpel make a number of cross scratches as in vaccination on the anterior surface of the fundus, and then pass a curved needle, threaded with silkworm gut, through the abdominal wall of one side, then through the anterior wall of the uterus, and then out through the other side of the abdominal wound. Three stitches are thus introduced at such a distance from the edge of the inversion that when they are drawn tight the abdominal wound is not only closed but also it is reinforced by the uterus behind it. I performed this operation twice last spring,

once on an Indian woman from Caughnawaga, sent to me by Dr. Patton of that place, in whom the uterus was hanging outside of her body and was bruised and bleeding from contact with her clothes. The pelvic floor was so relaxed that no pessary would have remained in. The operation only required twenty minutes, and was not followed by any pain or fever whatever. Her husband came to take her home on the 14th day, the stitches having been removed on the 10th day, but he declined to take a cab on account of the expense, and made her walk over a mile to the Bonaventure depot. I was anxious lest the new adhesions should have given away, but I have been informed by Dr. Patton, to whom I wrote to kindly examine her, that it was firmly attached behind the symphysis pubis. The other was a sad case of a single lady, sent to me by Dr. Brown, whose health and happiness had been wrecked and her life rendered wretched by prolapse of the left ovary, with retroversion of the uterus, the whole firmly adherent to the sacrum. I performed the same operation, but in addition removed the ovaries. I examined her a few days ago, nine months after the operation, and found the uterus still where I had sewed it; but it had become so atrophied that it was not larger than half the adult size. Both these patients are now in fairly good health.

I will reserve for a future communication some remarks on the early diagnosis of tumors of the uterus and appendages and the importance of early operation.

#### SIMPLE ULCER OF THE CORNEA; A CLINICAL STUDY FOR NON-SPECIALISTS.\*

By CASEY A. WOOD, C.M., M.D., Pathologist to the Illinois Charitable Eye and Ear Infirmary; Instructor in Ophthalmology Chicago Post-Graduate Medical School.

In a previous "Study" I endeavored to point out the characteristics of phlyctenular keratitis. Since the disease, in the later stages, is an ulceration of the cornea it

\* From the *North American Practitioner*, December, 1890.

might perhaps be classed under the above heading, but as it presents certain features which give it clinically a place by itself, it is usual not to include it in the category of corneal ulcers. Here is a case in point—a little boy aged 4, who has been complaining of his eyes for a month. He has a single, small, circumscribed ulcer occupying the lower-outer quadrant of the left cornea. Its edges and bottom are gray and infiltrated, and there is a prolongation of the infiltration outwards towards the periphery of the cornea. He has a sero-mucous discharge from his left nostril and his upper lip and left side of the face are swollen and dotted over with eczematous pustules. Most observers glancing at him would say, at first sight, that he has phlyctenular keratitis. On the other hand he has not and never has had marked photophobia, but sits upright and stares about the room. It is evident that he has not had that blepharospasm which leads the child with phlyctenular disease to bury his face on his mother's shoulder or to hide himself in some dark corner away from the light. Again, he has no traces of eczema behind the ears, at the corners of the mouth or about the alae nasi—as is often the case in true phlyctenular keratitis. The pustular eruptions on the face are the result of irritation produced by the continual discharge of tears over the cheek. In this respect and in the discharge from the nose the case does resemble the conditions present in corneal phlyctenulæ.

Using parallel columns one might contrast phlyctenular ulcer with the simple form.

<i>Phlyctenular Keratitis.</i>		<i>Simple Ulcer.</i>	
Results of bursting of a corneal pustule.	Pathology.	{	Infection of a corneal scratch or other wound.
Poor.	Health of patient.	{	Maybe very good.
Disease of childhood.	Age.	{	Usually found in adults.
Almost always multiple.	Number.	{	Almost always single
Very marked.	Photophobia and spasms of the lids.	{	Often not marked.
Usually present about head and face.	Eczema.	{	Usually absent.
Begins as a pustule.	Origin.	{	An ulcer <i>ab initio</i> .

But it does not often happen that we are

called upon to differentiate the solitary phlyctenula from the simple ulcer occurring in a child. Indeed the latter will almost invariably be found in *men* who pursue an active outside life. The genesis of the disease depends upon this, for in the majority of instances an ulcerated cornea begins by the removal of the protecting epithelium. This is followed by infection of the denuded spot by micro-organisms. These multiply and form a nest, whose sides and bottom are those of the ulcer. Abrasions of the cornea occur frequently with most of us and unless infection follows the trauma it is soon forgotten. Every time a foreign body enters the conjunctival sac every time a grain of coal, a spec of dust, or a piece of metal "gets into the eye" it may scratch the corneal epithelium and expose the individual to the discomfort and dangers of ulcer. If the person injured in this slight and insignificant manner have any purulent discharge about his person, if he be a sufferer from certain germ supplying affections in the immediate vicinity of the wound (such, for example, as blepharitis marginalis, the various forms of conjunctivitis, trachoma, nasal diseases, particularly ozæna, etc.) inoculation of the wound may follow and an ulcer form. Or he may convey to the abrasion from a soiled handkerchief, or from his hands some of those organisms that supply infection in other suppurations. Finally germs may float in from the air or they may be imported by the agent that first inflicted the wound.

*Simple Ulcer* of the cornea, then, as opposed to the virulent spreading variety, may be described as a small, generally single, generally central lesion with infiltrated edges and of a grayish white appearance. It does not tend to spread to any extent although the infiltration of its edges may become more evident. There is always more or less pericorneal congestion, though in some cases, where the ulcer is indolent; this sign may not be very well marked. We have a typical case here, a laborer, aged 28, who was injured a few weeks ago by

getting some sand into his right eye. I have reason to know that his surroundings are not the most sanitary in the world and I am therefore not surprised to learn that the abraded cornea did not heal up, but shortly after the hurt developed a superficial but central ulcer. In other words he has infected the primary corneal wound. His vision is now 6-18, or  $\frac{1}{3}$  of normal; he complains of some pain in the eye and he is unable to do his work. There is also considerable true photophobia, some pericorneal injection and a good deal of lachrymation. The ulcer presents the appearance of a rather dense central opacity, whose edges, translucent and grayish, gradually fade off into the transparent cornea. A close examination shows that the excavation made by the ulcer is a comparatively small and shallow one, and that its nebulous

edges are not produced by destruction of the overlying epithelium but are the result of an infiltration of tissue changes going on underneath the epithelial layer. Asking the patient to stand before the window in a half light we notice that when the bright image of its cross bars falls upon the centre of the cornea it is distorted or broken in one small and central spot only—indicating the whereabouts of the loss of substance. Outside of that the corneal epithelium presents an unbroken surface to the window image. The opacity surrounding the ulcer must be due to some change that underlies the epithelial layers of the cornea.

The following pictures will indicate what really does occur, and what the meaning of the infiltration is.

Figure 1 shows a vertical section of an

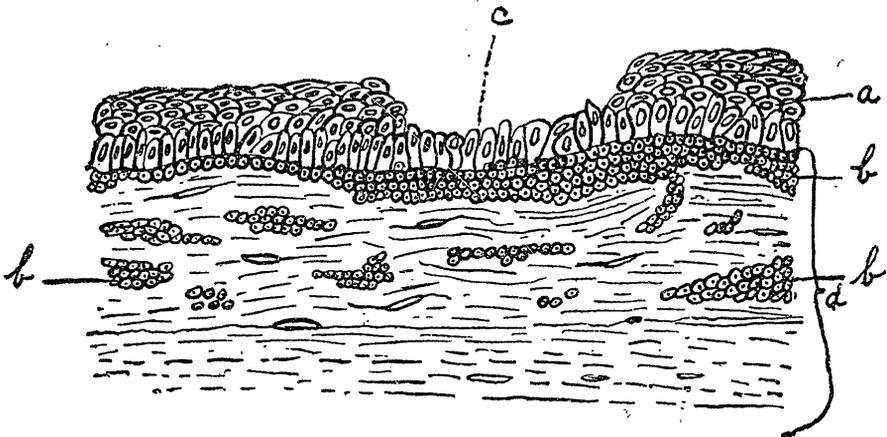


Figure 1. First stage of Corneal Ulcer.

*a.* Epithelial layer.  
*c.* A defect in it.

*b.* Collections of infiltrating round cells.  
*d.* Substantia propria.

ulcer in its earliest stage. Inoculation has occurred at *c* (where the epithelium has been removed), and the anterior elastic lamina has been destroyed, and its place taken by migrated round cells such as one observes in most inflammatory processes. Isolated collections of wandering cells (as at *b*) occupy various situations in the neighborhood, and add to the opaque appearance of the cornea. In both our patients, it is the congested vessels which have supplied these wandering leucocytes. Later on it

will be seen that, when under the influence of proper remedies, repair begins, these same vessels give off (new formed) branches which extend into the true substance of the cornea, and act as carriers of material whereby the corneal excavation is filled up.

In the second stage (see fig. 2), the entire epithelial layer is removed, and a free communication is established between the ulcerated portion and its surrounding collection of leucocytes. The ulcer is now filled with corneal debris, cellular masses, germs

and the products of the latter. The true substance of the cornea is invaded and the infiltration may extend half way through the thickness of the substantia propria. For several weeks this state of things may remain substantially unchanged, the remedies applied or the vitality of the tissues, or both forces working together, retarding the progress of the disease.

No new deposits of leucocytes are form-

ed. The active germs do not increase in numbers, and finally repair sets in. When that begins the peri-corneal blood vessels, whose capillaries apparently ended at the limbus, project small delicate processes into the substance of the cornea towards the ulcerated spot and repair goes on here pretty much as it does in other situations, with much the same results. This third stage is represented in Fig. 3.

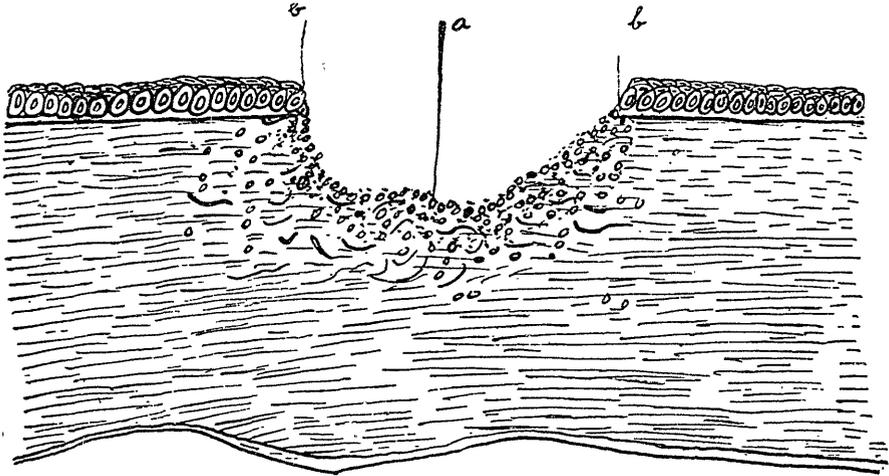


Figure 2. Second stage of simple corneal ulcer. The edges of the ulcer are at *b b*, where the epithelium and anterior elastic lamina end. The bottom of the excavation, *a*, is covered with tissue debris.

The outlying collections of round cells have been absorbed into the corneal lymphatic spaces whose contents finally empty into the pre-auricular lymph stream. When

repair is complete (as in Fig. 4), the new vessels disappear and the *hiatus corneae* is filled by connective tissue. In other words the sub-epithelial layer (of Bowman)

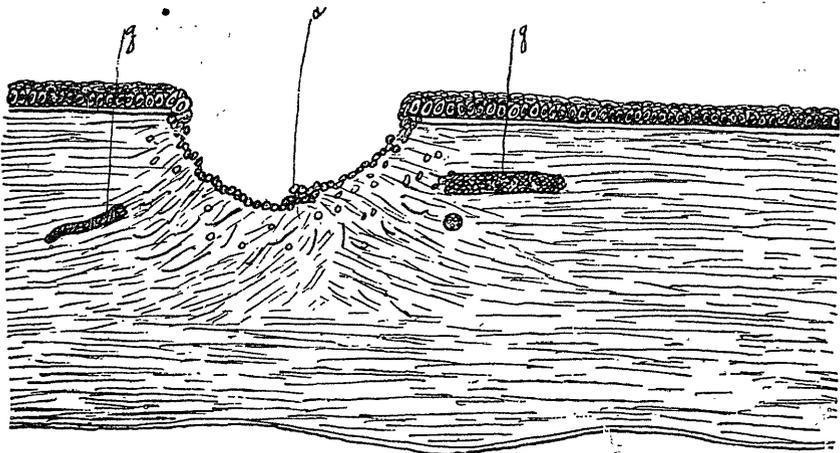


Figure 3. (After Saemisch.) Section of corneal ulcer. Beginning repair. The proliferating epithelium has covered the bottom of the ulcer *a*. New blood vessels have been cut through at *g*.

and the *substantia propria* once destroyed are not (in adults at least) regenerated. Their place is taken by a lower order of tissue and a true cicatrix is formed.

Otherwise is it, however, with the corneal epithelium. That is renewed by proliferation from the unaffected epithelium covering the edges of the ulcer (see Fig. 4), and so one observes, after healing of these lesions, a smooth surface, reflecting an unbroken "window image" even though the underlying scar tissue be abundant. As seen in figure 4 also, the new formed epithelium is more abundant than normal and sends processes into the cicatricial tissue beneath.

*Treatment.* It is very important that the simple ulcer should be efficiently treated as soon as possible so as to prevent or limit the damage which, when central, it often causes to vision. As before stated central scars, in adults especially, even when hardly

perceptible to the naked eye, may seriously lower the visual acuity. Two things are particularly desirable. 1st. That the infecting centre with its ramifications should be destroyed or removed, and, 2nd, that the healing of the ulcer should be promoted. There are several ways of attaining the former end. One may, as Noyes suggests, scrape out the little pocket of yellowish pus and germs with a spud, such as is used to remove foreign bodies from the eye. Or a small drop of a 10 per cent. solution of silver nitrate may, by means of a probe, be conveyed and accurately applied to the ulcer only. It should be allowed to remain for half a minute, after which a solution of salt (5 per cent.) kept ready for the purpose is used to wash it away. Great care should be observed that only a very small quantity is used, just enough to fill up or cover the ulcer. Another good plan is to whittle one end of a match to about one-

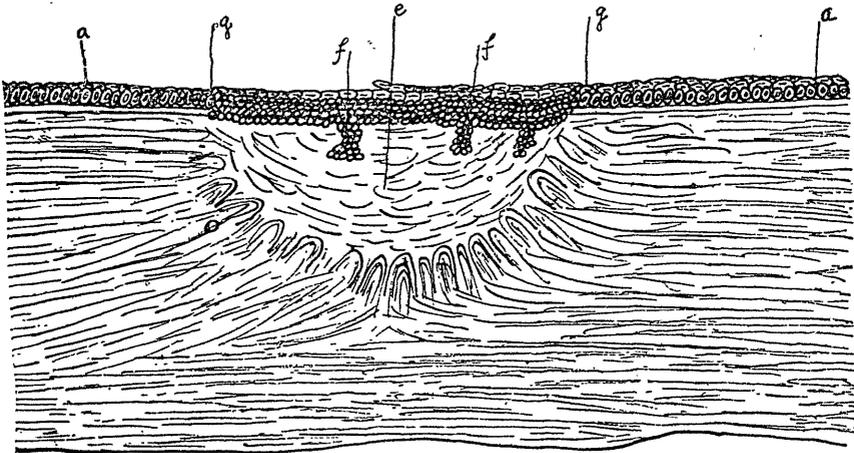


Figure 4. (Saemisch.) Cicatrized corneal ulcer. *a.* Epithelial layer. *g.* Edges of ulcer. *e.* Cicatricial tissue. The marginal epithelium has covered the scar, even (as at *f*) extended into its substance.

half its usual size, and having soaked it thoroughly in strong carbolic acid (95 per cent.) apply the medicated end several times to the ulcer until the part is quite white. Instead of strong carbolic acid a saturated solution of resorcin, applied like it, is effective.

Some surgeons prefer the electro-cautery

in these cases, but I think it produces too much scarring, and *unless the ulceration spreads*, as it rarely does in the simple form, is uncalled for. It is like taking a shotgun to kill a butterfly.

All these applications should be preceded by the instillation of cocaine—2-5 per cent. solution.

In any event the subsequent treatment will be about the same. It consists chiefly in bathing the eye thoroughly with hot water every 3 or 4 hours and putting in a few drops of a saturated solution of boracic acid to which some mercuric chloride (1:5000) has been added. Have the patient wear a close fitting patch or shield, under which, when it is windy or dusty, a piece of clean borated cotton is placed, but do not allow any bandage or handkerchief to cover the eye and retain decomposing discharges. Then, twice a day he should drop into his eye a couple of drops of a 1 per cent. solution of atropine. On bright days a pair of colored glasses will be needed to relieve the sympathetic photophobia which usually affects the sound eye.

It has been observed that certain cases, as yet ill defined, do not progress favorably under atropine. In such instances sulphate of eserine (0.25 per cent.) in a saturated boric acid solution should be substituted.

One may be sure that everything is going on well when the ulcer or its surrounding gray infiltration does not spread. The latter should disappear in a week or ten days, and soon new vessels (of repair) run out to the rim of the ulcer from the edge of the cornea. The pain, photophobia and lachrymation should grow gradually less until finally they disappear altogether; the ulcer fills up and leaves, let us hope, an inconspicuous and harmless scar.

It goes without saying that any blepharitis, ophthalmia, ozaena, or other infecting disease about the face should be cured. In the same way the patient should be warned never to wipe his eyes with his fingers, or to use anything but a virgin pocket handkerchief. Pieces of aseptic cotton wool are, however, best of all for eye wiping.

Finally, do not forget the rest of the organism, but see that the general status is not below par and that the patient has good food and healthy surroundings. Better put him into a hospital than allow him to reside in an ill-ventilated, ill-drained and germ-saturated house.

204 Dearborn street, Chicago.

## Correspondence.

### OUR BERLIN LETTER.

BERLIN, December 17, 1890.

(From our own Correspondent.)

Editor CANADA MEDICAL RECORD.

DEAR EDITOR,—Before coming to this city I spent about two weeks in London studying the effects of the Koch lymph at the hospitals which had procured the remedy. These hospitals were four in number, and I will give you a brief outline of the work and its results at each during the short time the treatment had been administered in London.

1st. *King's College Hospital*.—Here in the clinic of Mr. Watson Cheynne the largest number of injections of the lymph had been given, and to one who had watched the progress of the cases under treatment from time to time it seems incredible that the wonderful efficacy of the cure, in cases of lupus particularly, could be doubted. Lupus, which had been diagnosed as such by London's greatest surgeons, were sent to Mr. Cheynne for treatment by this remedy. The effect of the first injection, or perhaps the second, was readily seen, although certainly this effect was not invariable. Yet in the majority of cases the benefit was beyond all doubt. One could notice what was formerly an intensely congested lupoid tissue gradually lose its deep red color, becoming paler and crusting over with yellowish-white thick scales. These scales were shed, and in time the tissue beneath became cicatricial in appearance. In some lupus cases, it is true, this remarkable benefit was not apparent, but in a general way few cases of this disease were not appreciably benefited. Local tubercular conditions such as those of the ankle, knee and hip-joint, did not during the time treatment had been given, show strikingly good results, although Mr. Cheynne was sanguine regarding the future even in these cases. One case of enormously swollen, inflamed and suppurating strumous glands, with burrowing sinuses in the neck extending from ear to ear, together with the same state of things in one hand, was benefited by two (2) injections to a degree that would have excited the enthusiasm of the most skeptical. In eight days the hand was as free from disease as the other, only cicatrices remaining, while the state of the neck was improved at least fifty per cent. Even with this benefit, the patient, a young woman, refused to accept further doses of the remedy owing to the suffering she underwent due to the very great reaction in her case. Mr. Cheynne told me she had been almost in a state of collapse during the intensity

of the resulting fever. One case of an infant, 18 mos., with a fluctuating swelling of knee joint, which was injected with a dose of ( $1\frac{1}{2}$ ) one and a half milligrams showed good reaction and marked diminution of the swelling, but the future only could demonstrate any permanent benefit. In hip-joint disease no definite results have been noticed worth mentioning.

2nd. *City of London Hospital for Consumption*.—Dr. Herron gave the injections at this institution, with results of which the following is a summary. To begin with, I may say that this physician was the most cautious man that I have yet seen apply this powerful remedy. It is true, owing to this fact his results were somewhat tiresome, inasmuch as he had to inject from time to time without reaction until he reached the dose to which the patient was susceptible, and this was only done with safety by gradually increasing his doses. In cases of phthisis pulmonalis this is Koch's own method, and the only treatment admissible in my opinion to a conscientious man in handling a remedy so potent. Owing mainly to this precaution I did not see in London results of this treatment which I have already seen here—I mean in regard to undesirable sequelæ, such as lighting up a circumscribed pneumonia or a pleuritis the direct result of the lymph. Reaction producing these results would preclude further treatment until the subsidence of irritative symptoms, and then would be followed by diminished doses. Sometimes instead of high or moderate fever following, as a result of the remedy, the temperature would dip below the normal as much as a couple of degrees. This phenomenon Dr. Herron could not explain any more than he could explain the variety of exanthemata concurrently appearing while the reaction took place and lasting beyond it. In any case the rule is never to repeat an injection until temperature has reached the normal line again in phthisis pulmonalis. A practical point is in opening a new bottle of lymph invariably to begin again with the minimum dose, as Dr. Herron suggested the possibility of a varying strength in the fluid, and this precaution would decide any question about it. Without selecting any special cases from my note book, I can say that in a great many instances where no large cavities existed the physical signs cleared up very much and a general feeling of well-being was experienced after the reaction passed off. The slight loss in weight in some instances was followed by marked increase even upon an ordinary diet. In this hospital up to date nearly every case of night sweating had been benefited. I might say there was only one exception. In every case the urine was watched for any sign of renal complication, but with the exception of a slight opalescence in a few instances no result happened of consequence. Cases of phthisis where large cavities existed in the lungs were

not treated by the Koch method. They were looked on as incapable of sustaining the reaction. The temperature ranged from a dangerous height to a dangerous depression, and sometimes called for measures suitable to regulate these extremes. A case of anæmia, thought to be non-tubercular, was injected with a full dose, viz., 1 centigram, to find what effect would follow in this condition. Much to the surprise of all a general reaction followed with its train of symptoms, and local swelling of knee joints showed itself, proving the presence of tubercular tissue in the individual which previously had given no evidence of existence.

3rd. *London Throat Hospital* (Sir Morel McKenzie's).—Although the out patient practice at this hospital is great and the chief surgeon the most famous of English throat surgeons, yet the indoor facilities are very restricted, owing to the small building occupied, and consequently the number of patients treated by the Koch remedy is small, this treatment being essentially an indoor one, at least in the beginning. A very interesting case of a boy who had been operated on for œdema glottidis by tracheotomy to relieve tubercular laryngeal infiltration, was put on Koch's remedy. I fortunately arrived in London just in time to see the first work of the kind done here, so that the study of reaction in this case was carried out from the beginning. On comparing the condition of the throat after two injections with the condition previously, the subsidence of general inflammation was most marked, and the boy claimed that he was cured. (One very bad case of nasal and laryngeal lupus was not only improved in the general symptoms, but the intense redness of the tissue affected was very plainly diminished. Another case of this disease where the amount of tissue affected was small had almost entirely healed in a week. A few cases of lung tubercle not seriously advanced were also treated here with evidence of benefit. But in some cases the benefit was to my mind greatly assisted by imagination. The patients in many cases were intelligent and would in describing their symptoms remember that the wonderful Koch remedy, which they knew to be the talk of nearly all creation, must have done them good whether they felt it or not, and so their statements were largely biased. One case of cavity in left lung was not improved during the time I was in London; in fact he claimed his night sweats were worse, and he was weaker generally.

4th. *Brompton Consumption Hospital*.—The work done here by Dr. Theodore Williams was only started, so that no satisfactory data were recorded.

The whole work done in London had not been of sufficiently long duration to afford any reliable evidence of virtue in the remedy as a cure of a positive kind for tuberculosis. That many instances showed reaction resulting in decided and

positive benefit could be no more doubted than that many gave evidence of the reverse effect, but I admit that the latter were cases well advanced with cavities. The amount of misery caused by the reaction was bitterly complained of in many cases, and even amongst paupers positive refusal to allow further injections were made. Those who have watched the many hours of suffering through which a patient passes can sympathise with these objections. A condition of fever quickly advancing to a hyperpyrexia with a pulse of 140 to 160 a minute, pains in every part of the body, severe frontal headache, rigors, localized acute pain, as in resulting pleuritis, in some cases severe exanthemata, formication, paresis and other symptoms of a distressing kind, of a variety incredibly great, are what one notes during treatment. The remarkably successful results in some cases are what saves the remedy from banishment. At the height of crisis in reaction the sounds of pneumonic crepitation occasionally appear, with decided dull percussion note over an area where no such symptoms had previously existed, and which if they had could not have been overlooked. Happily these signs with all, or mostly all, of the others lighted up by the reaction resolve themselves and disappear on subsidence of the fever. This crepitation was thought to be a counter-part inside the chest of the action of this remedy on lupoid tissue external to it. That inasmuch as a halo of red extends beyond the lupus, with œdema and some obstruction to the circulation, so in the lung we have œdema lighted up around the tubercular deposits producing the signs mentioned.

Experience so far has established certain rules regulating the injections where the action is not only better tolerated but the physician kept less on the outlook for untoward results. I venture to say that the use of this remedy in practice, hospital or private, will be a most troublesome one to the physician unless in every case the nurses are of the most reliable character and capable of quieting the impatience of a sufferer while undergoing the miseries of reaction. In the children's ward of King's College Hospital I could pick out every child that had been injected from amongst others by listening to their cough. I have seen distressing cough last for almost an entire night as a result of injection. With very young children this is most frequently seen and passes off in a few hours generally.

When the injections cause no reaction the patients may be allowed to call at the physician's office, and receive his hypodermic, returning from time to time for another injection as the circumstances warrant or require, the object being to retain the system under the influence of the remedy. This procedure applies, however, more to lupus than tubercle. The oldest case of treatment of tubercle by the Koch remedy in Berlin Charité Hospital only

dates back to 4th October, and thus as yet any standard for prolonged treatment has not been established; in fact the entire question is in its experimental stage still, in many respects. At the same time a satisfactory study of the many thousands of injections made and a knowledge of results can only be obtained on this side of the Atlantic at the present time, and I may add Berlin is the place to come to if one is familiar with the language. Let me suggest to physicians intending to study this subject in Germany that unless they can appreciate lectures in German their time will be wasted here just now. Thus far the number of Englishmen studying the subject is not enough to warrant forming classes conducted in the English tongue. Demonstrations are given in every hospital and clinic only in German, and on this account some American M.D.'s who realized what I indicate have gone to London where they will acquire more light on the subject of this treatment. If any clinics are given in English I have not heard of them, but later no doubt English classes will be formed in this as in the other older subjects of study in Berlin. During the space of a few weeks one can study here amongst so many cases all the infinite variety of symptoms that arise under this treatment, and so gain an experience which one's personal administration of the lymph at home would not develop for a long time. The simple acquisition of the remedy, I would remind my medical friends, enables one to begin experimenting only, and to begin what was begun here some months ago. It is true the newspapers and medical journals have recorded the results here with much industry, but as is well recognized in other departments of medicine nothing but actual bedside experience can render a man competent to handle creditably so powerful a remedy and enable one to assure and satisfy anxious patients and their friends of what experience has shown in Europe the probable outcome will be. It is true that considered from a general standpoint the field here is only yet experimental, but three months constant use of the lymph amongst so many thousand cases would be the equivalent in result of as many years in Canadian hospitals.

A review of the work done here in the Charité Hospital, in the clinics of Von Bergmann, Gerhardt, Leu, &c., the polyclinics of Prof. Krause, Dr. Cornet, &c., I hope to send you next week. The last named gentleman is Koch's chief associate. Meantime I congratulate Montreal on getting some of the lymph.

G. T. Ross.

Hot claret is said to be an excellent gargle in Acute Sore Throat, being an agreeable astringent and non-poisonous.

## Progress of Science.

### TREATMENT OF ACUTE AND GONORRHOICAL RHEUMATISM BY PHENACETIN IN LARGE DOSES.

Rifat, (*Bulletin Général de Théraputique*, May 15th) reports the results of recent experimentation with phenacetin in rheumatism, both acute and blennorrhagic. He has treated sixteen cases; in three of these all the joints were swollen and painful. In the three grave cases which were attended with a very high fever, he was obliged to give large doses, fifteen grains every three hours day and night. In six of the cases he gave the fifteen grain dose only every four hours.

There is, he says, extreme tolerance by the stomach of phenacetin (an advantage which it has over antipyrine). It is well to begin treatment by giving only forty-five grains a day, that is, fifteen grains every three hours till three doses are taken. This dosage is, however, insufficient in rheumatic polyarthritis. Where he begins with three grammes (forty-five grains) *per diem*, he increases by one gramme (fifteen grains) a day till the pain has ceased, and the movements of the joints are restored. Ordinarily by the fourth day, when the daily dosage of six grammes (ninety grains) is reached, there will be noticed disappearance of the pain, freedom of movements, and absence of heat and swelling about the joints.

The maximum dosage, which is determined by the state of amelioration of the patient, is continued during the three following days—exceptionally, for a week; then the doses are gradually decreased by one gramme a day till the quantity of three grammes *per diem* is reached, and the medicine is continued in that daily amount for a week, when it can generally be discontinued.

In very severe cases it is necessary to continue the augmentation of doses till the fifth day, when the daily quantity has attained eight grammes (two drachms).

The treatment as above described, demands, in cases of average intensity, seventeen days; in grave cases, twenty-one days. It will thus be seen that the mean duration of grave cases does not exceed twenty-one days. If we compare these results with those obtained by Guttman with salicylic acid, whose mean duration was thirty-five days, and with antipyrin which gave a mean of twenty-five days, we see that phenacetin administered in the manner above described, appears to be the remedy to which preference should be accorded.

As for the secondary effects engendered by these large doses of the drug, Rifat sums them up as follows:

In patients treated by phenacetin, there may

be observed three sorts of phenomena imputable to the secondary action of this medicament, and which are: (1) profuse sweating; (2) cyanosis; (3) uræmic accidents.

Abundant sweats, especially in cases complicated with high temperature, are the rule; these are due to the hyperthermia, and when once the temperature falls to the normal, the sweating subsides. The sweats are wanting in apyretic rheumatism, and when they occur in the febrile form, they do not contraindicate the continuance of the medicine, whether this be phenacetin, antipyrine, or salicylate of soda. There is less liability to cardiac or other visceral complication when the remedy is pushed.

Cyanosis is a rare accompaniment of the administration of phenacetin. Rifat has not seen it in any of his rheumatic patients; in fact, he has never witnessed it but once, namely, in a case of typhoid fever.

Uræmic accidents are also very infrequent. They have, now and then, been witnessed in rheumatic patients with arterio-sclerosis and contracted kidneys as the result of suppression of the urinary excretion by the administration of phenacetin. Hence, it would be necessary when giving this remedy in large doses to nephritic patients to have surveillance of the renal functions, and to suspend the medicine if uræmic symptoms should appear.

Relapses are not very frequent, if the physician takes the precaution to continue the phenacetin after the method above indicated. If, however, the remedy be too early suspended, a relapse will be almost certain to follow. The same result has been noticed when salicylic acid or antipyrine has been given.

As regards blennorrhagic rheumatism, Rifat concludes, from an observation of three aggravated cases, that, in cases where salicylate of sodium has completely failed, phenacetin may have a real curative action. This disease is often most intractable, being the opprobrium and despair of the physician; though its pathogeny is doubtless widely different from that of acute rheumatism, yet in the cases reported by Rifat, phenacetin gradually pushed to six and eight grammes a day (certain auxiliary local measures, as compression being also employed) gave most satisfactory results, the pain and swelling rapidly subsiding, sleep and the power of movement returning. Unfortunately, three cases is too small a number to warrant a definite conclusion.—*Boston Med. and Sur. Journal*.

### HEADACHES.

The treatment of headaches of young children brings us into an almost special line of cases. In the city of New York, at least, these headaches are best treated, as a rule, by giving small doses of the iodide of iron, or of the citrate of iron and quinine. In school children, head-

aches have often to be treated by removal from school, the use of tonics, change of diet, and the application of glasses suitable to any eye-defects that may be present. But glasses should be the last thing tried, unless the visual trouble is very marked. In some children, arsenic acts well.

Headaches among brain-workers require, as a rule, a different class of remedies from those among muscle workers. In the former class, nervines, like antipyrin, caffeine, and the bromides, act well; while attention to diet, exercise, and the eyes is especially required. Among the laboring classes, especially women, anæmia, malaria, syphilis, and rheumatic influences must often be attended to. Among the best of symptomatic remedies is muriate of ammonium in large doses,  $\frac{1}{2}$  to 1 drachm, given in wafers. In the headache of neurasthenia, menthol, 5 grains in hot water, gives relief, or a combination of menthol, 5 to 10 grains, and antifebrin, in 5 to 10 grains. Phenacetin is also a good remedy. A practical point of importance in the use of antipyrin is the dosage. Often the best results are obtained by small doses frequently repeated. The much-advertised effervescent preparations for headache contain too small a dose of caffeine or of bromide to be of the best service. Of local applications, a spray or lotion of aconita, sheet lint soaked in 20 per cent. solution of menthol and wrapped on the head, solutions of cyanide of potash after the method of Trousseau, and Rithet's tobacco and quinine snuff, are some of the measures indicated.

Every one meets now and then with cases of headache of obscure origin, obstinate in character, and intractable to every kind of treatment. The use of iodide of potassium and of the strong galvanic current and static electricity has been of service to Dana in some such cases.—Hux, *Annual of Universal Medical Sciences.—Lancet-Clinic.*

#### THE CHEMISTRY OF GOUT.

When the microscope first unfolded the marvels of tissue structure to the gaze of the greedy seeker after knowledge, it was assumed that at last the secrets of nature were about to be unravelled, and that the finding of the appropriate remedies would be but a matter of time. Disappointment, however, has followed this department of research, and now that the microscopy of the tissues, normal and abnormal, has almost said its last word, we still seem as far from arriving at an explanation of the fundamental changes underlying many of what we are pleased to call diatheses, as were our forefathers. The microscope shows us the effects, while our object is to ascertain the cause, or at any rate the process of the phenomena. There is fortunately reason to hope that the prevailing obscurity may be dissipated by a better comprehension of physiological chemistry, a branch of study which calls for

peculiar qualities of mind and training. Of this we can recall no better example than the advances effected in the study of the chemistry of gout, a protean disorder the manifestation of which, thanks to Sir Alfred Garrod, we now know to be dependent upon, or at any rate to be associated with, some interference with or deficiency in the metabolic changes which take place in the organism, resulting in the presence of an excess of uric acid in the blood. The immediate determining cause of this excess of acid still eludes investigation, but there have recently been made known some observations of exceeding importance in regard to the behavior of acid in the blood and tissues under varying conditions of environment, throwing light upon the relationship of the excess of acid to the pathognomonic morbid phenomena of gout. It has been known as a matter of clinical experience that alkalies favor the elimination of uric acid from the system, while acids, on the contrary, diminish it.

The paper read by Sir Wm. Roberts before the Royal Medical and Chirurgical Society affords a scientific explanation of some of the points alluded to, and paves the way to further discoveries. As we have already stated in a previous article, this observer has demonstrated that uric acid in the blood exists in the form of a soluble quadrate. Under certain circumstances, especially if the alkalinity of the blood be lessened, or the excretion of the quadrate by the kidneys be unduly delayed, the salt combines with the sodium carbonate in the blood and forms biurate of sodium, a salt which is remarkably and persistently insoluble in blood serum. Synovia is less alkaline than the blood, and it is suggested that this fact may account for the deposition of the crystals of biurate in the joints, where they set up the local inflammation which characterizes the disease. The immediate effect of this disposition is to clear the blood to some extent of its superfluous acid, and this is quite consistent with the clinical phenomena observed after an attack of gout. When uric acid is treated with an alkaline solution outside the body, it is taken up as a quadrate. There, as in the body, it undergoes a process of what Sir Wm. Roberts calls "maturation;" and then, ultimately, suddenly breaks up into the biurate of precipitates. Direct observation on the behavior of uric acid in the laboratory shows that, *ceteris paribus*, precipitation earlier in synovia than in blood tissues, and this supports the hypothesis of the reason why the deposit takes place preferably in the joints. While, however, the stage of solution was hastened by increased alkalinity of the medium, no appreciable effect in retarding the period of maturation and precipitation was produced, and the addition of salts of sodium notably hastened these processes. The addition of salts of potassium, lithium or magnesium did not appear to have

any effect in either direction, with the exception of chloride of potassium, which seemed to prolong the period of maturation. The most important factor in determining the duration of the period of maturation was shown to be the proportion of uric acid present in the solution. The biurate is absolutely insoluble in alkaline media, and its solubility increases as the proportion of saline matter in the medium decreases. This perhaps explains how the "water cure" acts in clearing the system of its surplus acid. At the same time the paper inculcates the necessity for caution in the use of alkaline waters, which, if administered when the blood is charged with uric acid, may, by favoring the formation of the insoluble biurate, precipitate an attack of gout. Taken earlier, when there is still, so to speak, a margin of solubility, the alkaline may facilitate the conversion of the uric acid as it is formed into the soluble quadrate, thence to be eliminated by the kidneys if these organs are in good working order. The beneficial effects of alkalies would thus seem to be dependent upon prompt elimination of the uric acid, and an ample supply of liquids may aid this taking place. We may note *en passant* that the urates of iron and lead are extremely insoluble. We are probably only on the fringe of this important and recondite problem, for Sir Wm. Roberts hinted at the existence of a colloid form of the biurate, the sudden conversion of which into the crystalline form might account for the onset of an "attack."—*Med. Press and Circular* ~~*Lancet-Clinic*~~.

### SALICYLIC ACID IN DERMATOLOGY.

The germicide properties of this well-known agent have been carefully determined. Sternberg found that a pure micrococcus in active growth was destroyed by a 2 per cent. solution of the acid, and that the bacterium termo was killed by a like solution. As unusual skill and care is needed for the preparation of the pure acid, many samples to be had from druggists are unsatisfactory in their action upon the skin, chiefly on account of the presence of carbolic acid.

The action of pure salicylic acid upon the skin is quite peculiar. When a plaster or ointment containing from 38 to 50 per cent. of salicylic acid has been applied, the epidermis beneath it becomes gradually white and soft, so that it may be scraped off with the back of a knife. A reddened oozing surface is exposed, upon which, by the aid of a lens, the papillæ, rich in vessels and nerves, may be seen, projecting like so many carrots planted irregularly, with their roots up. Very little or no dermatitis is excited in the parts surrounding the application, except in cases of peculiar idiosyncrasy.

In the *Johns Hopkins Hospital Bulletin*, April, 1890, Dr. Morrison calls attention to these facts concerning salicylic acid, and mentions

certain cases in which he has found it of value. He first saw it used at a clinic at Prague in 1882, and found it in respect to cleanliness to greatly surpass and in efficiency to equal the ill-smelling tar preparations of the Vienna clinics. He uses it now quite extensively in his practice.

It is a good remedy for freckles and other pigmentations, as it readily removes these blemishes, and, in his experience, never of itself causes deposit of pigment. Through its germicide properties it quickly destroys the growths of tinea versicolor and ringworm. A case of chronic and very obstinate ringworm of the face and arm is cited, in which each spot was washed for five minutes with *sapo viridis* and warm water, and then covered with a solution of bichloride 15 grains and salicylic acid 60 grains in an ounce of collodion. There was intense pain and slight blistering, but no further application was required except lanolin containing 5 per cent. of salicylic acid. The cure was very remarkable.

Chronic eczema yields rapidly to the stronger salicylic acid preparations. In one case, a healthy man of forty-five years consulted him concerning a chronic squamous eczema of the wrist and palm. It worried the patient very much, especially when he became warm in bed, and had for two years resisted all treatment. A 38 per cent. salicylic acid plaster was applied and fastened tightly to the affected parts by means of a bandage. As the skin was not much affected after twenty-four hours, a fresh plaster was put on. This application, unlike the former one, caused intense pain, and upon its removal next day the epidermis was found to be soft and white. Without disturbance of the dead epidermis, a 50 per cent. ointment of salicylic acid in lanolin was rubbed in frequently and kept on by gloves. In from seven to ten days complete cure was produced. The patient was discharged, with orders to rub a little of the 5 per cent. ointment on the parts which had been diseased every time he washed with soap and water.

The salicylic acid treatment is of great value in psoriasis of long standing. A case is related in which a man had suffered for twenty years from psoriasis numulata et orbicularis, having large spots on the forehead and on both sides of the nose. *Sapo viridis* and hot water were used to remove the scales, and an ointment containing 60 grains of salicylic acid to the ounce of lanolin was rubbed into the affected skin. In a week considerable improvement was noticed, and at the end of a month only a slight discoloration could be observed on the face, which had once been greatly disfigured, and the lesions on the other parts of the body were also disappearing.

Salicylic acid may be applied in several different ways. It is only slightly soluble in water, but dissolves more readily in this liquid when sodium bichlorate is added. When it is desirable to apply it in powder to the skin, Dr. Morrison

prefers to make a saturated solution in alcohol, which dissolves it readily, and to allow the alcohol to evaporate leaving the acid behind in the form of a very finely divided powder. Unna rubs the powdered salicylic acid up with gelatine and glycerine, no solution being formed, but a useful mixture. Ointments of various strengths may be similarly prepared with lanolin. Unna has prepared plasters containing from 5 to 50 per cent. of salicylic acid, which have rubber backs and stick well to the skin.—*Maryland Medical Journal*.

### PYOKTANIN.

This new antiseptic, of the coal-tar or aniline series, is presented by its discoverer, Prof. J. Stilling, of Strasbourg University, as a true but harmless therapeutical disinfectant; that is, an absolutely sure and yet perfectly safe bactericide, eminently adapted for permeation through animal tissues and fluids in the living body. There are two varieties of this substance, blue and yellow pyoktanin, the former of which is the stronger. The different forms in which this substance is presented for use are as follow:—

1. Pure pyoktanin, in divided powders, is used on the surfaces of large purulent wounds and ulcers, until a firm scab has formed; the scab is then left to spontaneous desquamation.

2. Pyoktanin dusting powder (2 per cent.) may be sprinkled on skin abrasions, moist eczemas, and the like.

3. Pyoktanin dusting-powder ( $\frac{1}{10}$  per cent.) is more especially indicated for ophthalmology, in the milder forms of conjunctivitis, and in slight inflammations of the petuitary membrane.

4. Pyoktanin ointment (2 per cent. to 10 per cent.) is eligible in chronic marginal blepharitis, in eczemas, and in all those cases where the 2 per cent. dusting-powder is indicated.

5. Pyoktanin pencils (the large size) are used in minor surgery for the sterilization of fresh wounds, in small purulent wounds and ulcers (which, however, must not be much larger than a silver dollar), in small burns and scalds, in paronychias, etc. The pencil is dipped into water, and then passed over the traumatic surfaces until a continuous coat of color is apparent over their entire extent; thereupon they are abandoned to spontaneous desquamation. The small size is used principally for ophthalmological purposes, as the sterilization of purulent corneal ulcers.

6. Pyoktanin solutions ( $\frac{1}{1000}$  to  $\frac{1}{100}$ ) are used in conjunctival and corneal affections. For surgical use, the strength of the solution varies from  $\frac{1}{10000}$  to  $\frac{1}{1000}$ . Solutions of the latter strength are employed for general disinfection, in spittoons of consumptives, etc.

7. Pyoktanin surgical dressing-materials ( $\frac{1}{10}$  per cent.) are used for the bandaging of wounds, etc.; for the antiseptic stuffing of cavities, the

gauze must be impregnated with pure pyoktanin.—*Merck's Bulletin*, June, 1890, p. 49 *et seq.*

Dr. Carl, of Frankfurt, finds that in mucous affections of the eye all favorable influence must be denied to pyoktanin of methyl-violet aniline.

In abscesses of the cornea the action in some cases was good: but in no instance could Carl note any improvement due to the action of the remedy. In 1 case of *ulcus serpens* an interlamellar infiltration was generated by the use of methyl-violet, and then a ring-abscess was found which dissolved the cornea. This case prompts Carl to warn against the indiscriminate use of methyl-violet. Further unfavorable results with pyoktanin treatment are reported by Braunschweig, of Grafe's clinic. Braunschweig treated 70 cases of diseases of the eye with pyoktanin. In not a few cases pyoktanin proved to be directly harmful; frequently severe pain was noted after instillation, and not infrequently conjunctivitis ensued, accompanied in 3 cases by pseudocroupous collection; in some cases keratitis was induced.—*Berliner klinische Wochenschrift*, No. 37, 1890.

Pyoktanin is merely a trade-marked name for aniline, any shade (blue, yellow, red), chemically pure, free from arsenic and the fact that these products have antiseptic properties was published eighteen years ago in St. Louis by Dr. Charles O. Curtman, and many American physicians and surgeons in various localities have been quietly using aniline antiseptic solutions ever since.—*Notes on New Remedies*, October, 1890.—*Satellite*.

### IODIFORM AND CREASOTE AS AN INHALATION IN PHTHISIS.

The following inhalation is recommended by Brunton in the treatment of phthisis.

R.—Iodoform,	24 grains.
Creasote,	4 minims.
Oil of eucalyptus,	8
Chloroform,	48 “
Alcohol,	} equal parts to make $\frac{1}{2}$ ounce.
Ether,	

To be used in a Robinson's inhaler.—*Virginia Medical Monthly*, August, 1890.

Salicylate of mercury is now administered in Syphilis, says the *Therapeutic Gazette*, June 16th, 1890, internally in the dose of from 1-64 to 1-25 of a grain in pill form two or three times daily, or it may be given in the form of intramuscular injection in the amount of  $\frac{1}{8}$  of a grain with an equal amount of potassium carbonate. Externally this salt has been employed as dressings or as salves in syphilitic ulcers and mucous patches, and as an injection for gonorrhœa with potassium carbonate in the strength of 6, 15, or 45 grains to each quart of water.

## TREATMENT OF TUBERCULOSIS WITH BORACIC ACID.

For the past five years, Dr. Gaucher has been studying the action of boracic acid on pulmonary tuberculosis. He has recently made public the results which so far have accrued from his researches. He first of all determined by means of experiments on animals the toxic limits of the acid when administered internally, and he found that this stood at the ratio of about a gramme to a kilogramme of the animal's weight. As to its subsequent elimination from the system, he found that this took place very readily and even rapidly by way of the renal secretion; there was therefore little fear of any accumulation or tardy cumulative action. But what was an equally important and desirable result, he found that the boracic acid was also eliminated appreciably through the expectoration; the sputum of tubercular patients whom he had subjected to this treatment was found to be very freely charged with the acid. Some of his experiments are not only interesting, but certainly encouraging in their ascertained results. For example, he took two or three rabbits and injected into their lungs through a needle syringe a few drops of a solution of pure tubercular culture. In this way he set up a local tuberculosis which became caseous but not generalized. Some of the animals soon succumbed to pulmonary tuberculosis, and the surviving ones were shortly after destroyed. Well-marked phthisis was found in all post-mortem. He next repeated his inoculations on healthy rabbits in precisely the same manner, but he now fed the animals on bran mixed with boracic acid. After a time these also were sacrificed, but, contrary to what he found in his initial experiments, their lungs were quite free from any tubercular lesion, neither was any found elsewhere. It is submitted that, although these experiments on rabbits may not be altogether conclusive as to a like action of boracic acid on human tubercular subjects, they are at least—in the face of the enormous mortality from phthisis and hopelessness of therapeutic methods in general in this disease—worthy of serious attention and more extended trial. As to clinical results, so far as it has been tried, the boracic acid treatment has been found to bring about a notable diminution in the expectoration, which became more fluid and less purulent. Considerable time is, of course, necessary before speaking of remote or final results, but in the cases in which the treatment has been tried, and which have been under observation for a considerable period, it may be said that in general they improved in every way, while the tubercular trouble in the lung appeared to be at a standstill. The dose administered in these cases was one gramme in divided doses in the twenty-four hours. This, on the weight theory, must be considered insuffi-

cient. Taking the average weight of a patient to be sixty kilogrammes, and putting the limit of dose at twenty centigrammes for every three kilos, four grammes of the acid should be given per day, the dose being, of course, graduated up to this amount. Boracic acid will be found as a rule to agree well with the stomach, and is easily taken; it is not caustic, has no disagreeable taste, and in some cases was found even to check diarrhoea when this existed.—*Paris Correspondent, Lancet.*

## A RATIONAL TREATMENT OF SCIATICA.

For the relief of pain in very severe cases says Hammond, (*N. Y. Medical Journal*), it is absolutely necessary to use morphine. It should be injected hypodermically, as near the nerve as possible. In milder cases, phenacetin, antipyrine or acetanilide might be used. To relieve the neuritis, dependence is placed almost entirely upon rest, the application of cold, and the use of electricity.

Absolute rest is attained by keeping the patient in bed and employing the old-fashioned long splint, reaching from the axilla to the sole of the foot. It should be attached so as to leave the thigh and sole uncovered for the use of electricity. The splint should be removed for a short time every fourth day, in order to manipulate the joints and muscles to a slight degree. Cold should be applied to the sciatic region by means of ice bags.

Electricity is very useful, and only the continuous current should be employed, and in the following manner:

The negative electrode should be nine by four inches in size and should be strapped to the sole of the foot. The positive electrode about five to six inches square should be applied over the gluteal region, over the point of the exit from the pelvis of the sciatic nerve. If there are any tender points along the course of the nerve, this electrode should be changed occasionally, so as to cover them. The strength of the current should not be such as to cause much pain, but should fall short of this. The continuous current should be applied twice daily for about five minutes at each *séance*.—*Lancet Clinic.*

## SALOL IN CYSTITIS.

One of the commonest ailments among women which the general practitioner is called upon to treat, and which seems to be peculiarly prevalent in this class of patients, is a troublesome cystitis, due possibly to derangements of the pelvic circulation. Not rarely a very considerable amount of difficulty is experienced in overcoming the affection, which not only disturbs the rest of the sufferer, but often also very seriously affects her

mental state, causing her to be irritable, nervous, and a source of discomfort to all around her. For the treatment of such cases, resort has been had to innumerable remedies, and success has been claimed in this connection for the most dissimilar drugs and methods. Most frequently the cause of the distress is a vesical catarrh, the cure of which affords more or less complete relief of the condition. At other times the treatment which is found to be called for is constitutional rather than local; and cases also are met with that necessitate a union of both procedures. To this probably it is attributable that the recommendations of different practitioners cover so wide a range of ground, while it explains too, the reputed success of those who claim to have met with good results from the employment of medicines newly introduced into the Pharmacopœia. The drug most lately reported as being curative of the form of cystitis in question is salol; and three obstinate cases which were completely cured by its administration are described by Dr. Abbot in the *Boston Medical and Surgical Journal*. Each of the patients had been suffering for a considerable time, and had been treated with palliative means with more or less success, but without any permanent relief being obtained. The dose of salol given was ten grains three times a day, and in each, marked improvement of the symptoms was very speedily observed. One most satisfactory feature in the history is the rapidity with which the cure was effected, a week or ten days sufficing to bring it about in all three instances. When we remember that even months of treatment by other means may terminate in disappointment, it may well be considered that a method which promises so favorably deserves the widest possible trial, and no doubt the usefulness of the drug in question will soon be tested on a larger scale than has hitherto been the case.—*Med. Press and Circular*.

### LAPAROTOMY FOR PERFORATING TYPHOID ULCER.

There can be doubt that the question of whether or not laparotomy for the relief of perforation of the intestine, which is apt to occur in the course of typhoid fever, is a legitimate operation must be answered in the affirmative. Although it is the case, we believe, that no successful result has so far been recorded, we need not necessarily conclude that under favorable circumstances recovery from so serious a lesion with the aid of operative interference is impossible. Kussmaul, of Strasburg, Bartlet, of Birmingham, Morton, of Pennsylvania, and Senn, of Milwaukee, have each recorded a case of laparotomy for typhoid perforation. The patients, unfortunately, all died, the deaths taking place between the limits of three and

eleven hours respectively. Again, Kimura, of the Naval Hospital at Yokosuka, in Japan, opened the abdomen of a man, aged thirty-four in whom symptoms of perforation had developed in the course of an attack of typhoid. The operation was performed twenty-eight hours after the symptoms occurred. The peritoneal cavity was found to contain a large quantity of feculent matter, and the intestines to be covered with lymph. A perforation, the size of a small pea, was discovered in the small intestine about two inches above the cæcum. The edges of the perforation were inverted by the surgeon, and completely buried with ten interrupted Lembert sutures. The vermiform appendix, also being acutely inflamed and much changed in color, was ligatured and removed. The abdomen was thoroughly cleansed with a warm solution of dilute boracic acid, and antiseptic dressings applied to the wound. After recovering from the anæsthetic, the patient was cheerful, and quite free from the pain, which before had been agonizing. About eight hours afterwards, however, violent pain in the abdomen recommenced; in the course of a few hours more collapse set in, and the man succumbed. At the post-mortem examination it was found that one of the sutures had involved part of an ulcer, and this leading to the giving way of the suture, extravasation had recurred. This case, as well as all those in which laparotomy for this lesion has been attempted, only shows more clearly the necessity of operating without the least delay as soon as perforation as supervened.—*Med. Press and Circular*.

### SURGICAL TREATMENT OF TUBERCULOUS PERITONITIS.

M. Maurange (*Nouv. d'Obstétrique et de Gynec.*, September, 1890) has collected statistics of seventy-one cases in which abdominal section had been performed for tuberculous peritonitis; 83 per cent. were operative successes, and of these about half were doing well one year after the operation. In many cases which afterwards died of other tubercular affections the peritoneal lesions were found completely cured. The precise way in which cure of the local affection is brought about by abdominal section is not clear; many theories have been advanced. M. Maurange maintains that the operation simply places the patient in a condition favorable for cure by unburdening the peritoneal cavity of its ascitic effusion, which is, moreover, a true cultivating fluid. The proceeding also insures antiseptis. Abdominal section is not only advisable in cases where a localized tuberculous area exists, but also in cases where the patient's general condition grows worse, and where the disease spreads whether ascites exists or not. Some surgeons are content to open the peritoneal

cavity; others flush it with antiseptic lotions, dress it with iodoform, or drain. M. Maurange has seen good results follow a less extreme practice than abdominal section. The ascitic fluid is removed by aspiration; antiseptic washing with subsequent evacuation of the fluid follows the aspiration, and lastly variable quantities of a mixture are injected into the peritoneum. This mixture consists of four grammes of iodoform dissolved in one hundred grammes of liquid oil of vaseline. This injection can be safely repeated, considering the small proportion of the iodoform and the weak absorbing power of the diseased peritoneum.—*Supp. Brit. Med. Jour.*

### EPSOM SALT IN THE TREATMENT OF DYSENTERY.

Surgeon A. W. D. Leahy, of India (*Lancet*, October 4, 1890), has treated 103 cases of acute dysentery by the administration of a saturated solution of sulphate of magnesium, to which was added a small quantity of dilute sulphuric acid. In the early stages of dysentery this treatment, as the author has found, is remarkably efficient; the temperature falls, mucus and blood disappear from the stools, which become copious, fæculent, and bilious; tenesmus ceases; the skin acts well, and the patient sleeps after the first few doses. The more chronic the case, the less apparent are the advantages of the treatment.

The method is carried out as follows: A drachm of the saturated solution of the salt with ten drops of dilute sulphuric acid are given every one or two hours, until the stools become more copious, fæculent, and free from blood and mucus, the temperature falls, and the pain and tenesmus cease. When the stools are normal in character and are reduced to two or three in the twenty-four hours, an ordinary astringent mixture with opium or cannabis indica is usually all that is necessary to complete the cure.

The advantages of this method over the usual ipecacuanha treatment are, that it has no depressing effect; that it produces neither nausea nor vomiting; and that it quiets and soothes the patient. It probably prevents the formation of ulcers by its influence upon the hyperæmia of the bowel.

### SUPPOSITORY FOR CYSTITIS.

R.—Iodoform,	24 grains.
Extract of belladonna,	$\frac{1}{2}$ grain.
Cacao butter,	45 grains.

Pass this well into the bowel, and morning and night inject into the rectum hot water. If any inflammation of the urethra occurs or is present, 1 grain of terpine or salol may be given in pill twice a day.

### THE DRY METHOD OF TREATING WOUNDS.

Dr Hal C. Wyman, of Detroit, calls attention to this valuable method of treating wounds. The treatment consists in drying the wound with hot, dry towels taken from an oven where they have been heated to 212° F. (100° C). No water is allowed to touch the wound or the adjacent parts, from first dressing to final healing. Loose fragments are removed; all tissues bruised beyond repair are cut away with scissors; blood and dirt are scraped away with hot, dry towels. All lacerated parts are approximated and held with sutures which have been freshly sterilized by dry heat. Then a dry mixture of Wyeth's impalpable powder of boracic acid (7 parts) and iodoform (1 part) is rubbed into the wound along the lines of approximation. Over this are laid strips of dry iodoform gauze. Over them oakum freshly sterilized by heat, and over the okum freshly sterilized cotton, held in place by a roller bandage fresh from the oven.

The dressings are allowed to remain undisturbed until healed, unless pain, rise of temperature, or soiling of the dressing by discharges, indicates that fresh dressings are needed. This method, he claims, favors the cleaning of the wound, favors the control of hemorrhage, diminishes the tendency to fermentation and putrefaction, hastens the repair of wounds, and insures the healing of flaps and ragged pieces which by the wet method would slough.—*The Dixie Doctor*, September, 1890 *Satellite*.

### PALPITATION OF THE HEART.

Dr. Nebo (*Journal de la Sante*), says that an excessive palpitation of the heart can always be arrested by bending double, with the head downward and the hands pendent, so as to produce a temporary congestion of the upper part of the body. In almost all cases of nervous or anæmic palpitation, the heart immediately resumes its natural function. If the respiratory movements be suspended during this action, the effect is only the more rapid.

[We saw a demonstration of this feat by an intelligent friend who was subject to wildly irregular heart, but have never seen it in print before].—*Southern Clinic*.

### TREATMENT OF OZÆNA.

Cozzolini recommends the following powder for the treatment of this troublesome affection:

R.—Salol,	2 drachms.
Boric acid,	1 drachm.
Salicylic acid,	12 grains.
Thymol,	5 "
Powdered talc,	3 "

Use as an insufflation.

—*Provincial Medical Journal*, August, 1890.

## ACETANILIDE IN TYPHOID FEVER AND THE HECTIC FEVER OF TUBERCULOSIS.

According to the observations of Dr. A. Favrat on a large number of cases under the care of Professor Sahli (of Berne), acetanilide, administered in doses of 0.05 to 0.10 gramme ( $\frac{3}{4}$  to  $1\frac{1}{2}$  grains) every hour or two, according to the susceptibility of the patient, or 0.20 to 2.0 grammes (3 to 30 grains) daily (0.50 to 0.80 gramme— $7\frac{1}{2}$  to 12 grains—being the usual amount), gives great subjective relief to the patient, and effects a marked and persistent decline in the temperature, without the inconveniences and dangers of the same medicament taken in larger doses at longer intervals (collapse, cyanosis, chilliness, profuse sweats). The antipyretic effect is, moreover, most marked when the fever is very intense. After a dose of 5 to 10 centigrammes ( $\frac{3}{4}$  to  $1\frac{1}{2}$  grains), the temperature declines generally  $1^{\circ}$  C. ( $1.8^{\circ}$  F.) sometimes even  $2^{\circ}$  C. ( $3.6^{\circ}$  F.), and this lowered temperature may be maintained by the subsequent doses of the remedy.

The use of acetanilide, however prolonged, does not produce any unpleasant effects.

In infants, the dose need not exceed 1 or 2 centigrammes ( $\frac{1}{8}$  to  $\frac{1}{2}$  grain).—*La Semaine Médicale*,—*Satellite*.

## ALKALIES IN DYSPEPSIA.

M. Germain Sée, in an article published in the *Semaine Médicale*, says that alkalies frequently fail to do good in dyspepsia, owing to improper methods of administration. He recommends that 3 to 4 grammes (45 to 60 grains) of sodium bicarbonate, dissolved in warm water, be given at the time of the greatest acidity, which is generally two or three hours after meals. Smaller doses do not sufficiently neutralize the acid, while larger ones may do harm by leaving the stomach contents alkaline, the object being to keep the gastric juice at its normal acidity. In dyspepsia, with insufficient secretion of hydrochloric acid, such as is met with in anæmia and neurasthenia, alkalies in small doses should be given half an hour before meals. It has been experimentally shown that this increases the amount of acid secreted. General hygiene and dietetic treatment should not be neglected.—*British Medical Journal*, October 4, 1890, Suppl., p. 6.—*Satellite*.

## HOW TO WASH OUT A BABY'S STOMACH.

Dr. A. Seibert (*The Dixie Doctor*, April, 1890), says: A No. 10 soft rubber catheter is attached to a glass tube six inches long. The operator is seated before the child, which is held

upright (as in throat inspection) or on one side. The left index-finger of the operator is held between the right upper and lower maxilla, just so as to prevent the mouth from closing. Then the tube is passed over the tongue into the pharynx, the head of the child inclining slightly forward. By gentle pressure we overcome the spasmodic constriction of the upper pharyngeal muscles, and then the catheter glides easily into the stomach. Now, the left hand holds the catheter and the right attaches the lower end of the tubing of the fountain-syringe or regular irrigator over the glass tube attached to the catheter. Water is now allowed to flow, and after the stomach is filled, the supply is shut off, the tube detached, and the end of the glass tube lowered below the child's umbilicus, so the contents of the stomach come up very nicely. Never use force. No trained assistant is necessary. The tube will never enter the larynx. The younger the babe, the easier it is to wash its stomach.—*Lancet-Clinic*.

## HYPODERMIC INJECTIONS OF PILOCARPINE.

Dr. Holtenhoff, of Geneva, recommends that the utmost caution should be used in regard to subcutaneous injections of pilocarpine. He has observed cases where even 1-100th gr., or 1-75th gr., of the drug gave rise to such disagreeable accessory effects as collapse with cold sweats and an agonizing sensation of impending dissolution. Not more than 1-200th gr., should be the dose to commence with. According to the author's estimation, even 1-100th grain may prove sufficient to kill an adult man.—*British Medical Journal*.

## TREATMENT OF SYCOSIS.

Rosenthal applies the following in this condition:

R.—Tannic acid, 15 grains.  
Milk of sulphur, 30 "  
Vaseline, 5 ounces.—M.

During the day no applications are used, but at night the ointment is thoroughly applied. The following, recommended by Hebra, may also be resorted to:

R.—Tannic acid, 75 grains.  
Milk of sulphur, 150 "  
Oxide of zinc, } of each 9 drachms.  
Starch, }  
Vaseline, 1½ ounces.—M.

After the ointment is applied, it is covered with iodoform-gauze.—*Rev. Gén. de Clin. et de Thérapeutique*.

## ANTIPYRINE IN ERYSIPELAS.

Dr. Favre, of Fribourg, says the *British Medical Journal*, has reported an unusually severe case of erysipelas showing the high curative value of antipyrine. A woman, aged thirty years, suffered from facial erysipelas accompanied by somnolence, vomiting, constipation, and high fever. In spite of application of cold carbolic acid, ichthyol, corrosive sublimate, strips of adhesive plaster, etc., the morbid process gradually extended over the scalp, neck, chest, upper extremities, abdomen, and buttocks. On the tenth day the administration of antipyrine was begun, with the result that the febrile symptoms were at once decidedly reduced, the eruption soon ceased to spread, and the patient's subjective state was greatly improved.

## DIURETIN.

This substance is a sodio-salicylate of theobromine, and possesses certain properties common to theobromine, and caffeine, although it does not cause the mental excitement and wakefulness which so often result from the use of caffeine. Diuretin has produced well-marked diuresis in many cases of dropsy associated with disease of the heart and kidneys, and its place in therapeutics appears to be close to that hitherto occupied by digitalis and strophanthus. The substance is fairly soluble in warm water, and remains in solution on cooling, but it has the disadvantage of undergoing changes rather rapidly unless kept in well-stoppered bottles.—*The Lancet*, October 11, 1890.

## A TEST FOR DRINKING-WATER.

A test for the purity of drinking-water is given as follows by Professor Angell, of the Michigan University: "Dissolve about  $\frac{1}{2}$  teaspoonful of the purest white sugar in a pint ( $\frac{1}{2}$  litre) bottle completely full of water to be tested, tightly stoppered; expose it to the day light and a temperature up to 70° F. (21.11° C.) after a day or two examine, holding the bottle against something black, for floating specks, which will betray the presence of organic matter in considerable proportion."—*Cincinnati Lancet-Clinic*, July, 1890.

## LOCAL ANÆSTHESIA FOR MINOR OPERATIONS.

In minor surgical operations, incision of a paronychia, evacuation of a glandular abscess, extirpation of a superficial epithelioma, etc., M. Dobisch, of Zwittau, uses, with success, the

following solution in spray to obtain local anæsthesia:—

℞ Mentholi, . . . 4.0 grammes (ʒi).  
Chloroformi, . . . 40.0 " (ʒxx).  
Ætheris sulph., . . 60.0 " (ʒxxv).—M

The local anæsthesia lasts from two to six minutes.—*Allgemeine Medicinische Central Zeitung, L'Union Médicale*.

## SYPHILITIC ULCERATIONS.

M. Plumert gives the following formulæ:—

℞ Hydrarg. salicylat.,  
Potassii carbonat., āā 1.00 gramme (gr. xv).  
Aquæ destillatæ, 100.00 grammes (ʒiij).—M

Ft. sol.

Sig.: Bathe the ulcerations with the lotion, or apply compresses wet with the same.

The following ointment may also be used:—

℞ Hydrarg. salicylat., 1.00 gramme (gr. xv),  
Vasellini . . . 30.00 grammes (ʒij).—M.

This ointment is also efficacious in eczema.—*L'Union Médicale*, October, *Satellite*.

## THE TREATMENT OF BULLET WOUNDS.

M. Rochet, after discussing the widely different opinions of the older surgeons, Paré, Sedillot, Larrey, Percy and others, who advocate the immediate removal of bullets, and those of Trélat and Verneuil, who advocate allowing them to remain, concludes that the danger of searching for the foreign body is often greater than allowing it to remain, since in case, of bad after-effects, endangering life, the search can be made then as well as at the immediate time of injury. He advises, however, immediate operation in case of wound of important organs where it is possible to reach the foreign body with the knife.—*Gazette des Hôpitaux*.

## BROMIDROSIS OF FEET.

Scott recommends the following:

℞.—Biborate of sodium } of each 2 drachms.  
Salicylic acid, }  
Boric acid, } 30 grains.  
Glycerin at -86° F. } of each 1 ounce.  
Alcohol, }

Mix, and use as a wash three times a day.

This application is particularly useful in those cases where much maceration of the skin is present, and where remedies of other kinds have failed.—*Medical News*.

### OINTMENT FOR SYPHILITIC ALOPECIA.

According to *L'Union Médicale*, July 31, 1890, Mauriac recommends the following application for the relief of syphilitic alopecia:

R.—Sulphate of quinine, } of each 7½ grains.  
Turpeth mineral, }  
Suet, 1 ounce.

Make this into a pomade, and apply night and morning. Every second day use the following wash:

R.—Carbonate of sodium, } of each 15 grains.  
Boric acid, }  
Distilled water, 8 ounces.

If the disease persists, a lotion of mercuric chloride of the strength of 1 to 500 or 1 to 1000 may be used, or in other instances yellow precipitate ointment will be more efficacious.

### TREATMENT OF CHANCRES BY CREOLIN.

In the *Bulletin Générale de Théraputique*, July 15, 1890, Busque, of Brazil, writes a note to Dujardin-Beaumetz, detailing his experiences in the treatment of chancres by this means.

His custom is to apply to the sore a solution of the strength of from 12 to 20 parts to 1000, and he believes that the progress of the malady is shortened and relief speedily obtained. Compared to iodoform Busque thinks these solutions of creolin equally serviceable. The best treatment, however, is to combine these drugs, using the creolin solution as a wash and then iodoform as a dressing.

For eczema of dentition, treatment is to be directed to three indications (*Gazette Hebdom.*, in *Annals of Gynecology and Paediatrics*, July, 1890):

1. To calm pruritus of the gums, frequent rubbing with the finger dipped in a solution of the following:—

R. Cocaine hydrochlorat., gr. j  
Potass. Bromid., gr. x  
Glycerin,  
Aque destilat., āā f ̄ss M.

2. For insomnia a dessertspoonful hourly of:

R. Sodii bromidi, gr. xij  
Syrup, aurant. flor., f ̄ij M.

3. For the local eczema the following:—

R. Zinci oxid., gr. xx  
Vaseline, ʒj. M.

### ACETATE OF AMMONIA IN SCARLET FEVER.

After experimenting with acetate of ammonia in scarlet fever, M. Vidal arrives at the following conclusions:—

1. Acetate of ammonia is well tolerated in

the human organism in the dose of 1 gramme (15 grains) per year of age, in infants as well as in adults. I do not, however, in the adult, exceed a daily dose of 35 grammes (1½ ounces).

There is reason to believe that, in this dose, acetate of ammonia, in rapidly lowering the high temperature of the body, constitutes a valuable means of treatment in scarlet fever, and, perhaps, also in other eruptive fevers.

3. The action of this remedy has always appeared more quickly when it has been administered very early in the disease.—*L'Union Médicale*, August 9, 1890, p. 202.

### FOR PSORIASIS.

Mr. Jonathan Hutchinson's favorite prescription for psoriasis is:

R Acid. chrysophanic., grs. x.  
Liquor carbonis detergent., ℥x.  
Hydrargyri am. chlorid., grs. x.  
Adipis benzocat., ʒj.—M.  
Fiat ugentum.

At night the patient should wash the diseased surfaces free from all scales; then, standing before a fire, rub on the ointment, devoting, if possible, half an hour to the operation.

Mr. Hutchinson somewhat doubtfully prescribes arsenic internally along with the above.—*Archives of Surgery*.

### OINTMENT FOR PITYRIASIS VERSICOLOR.

R.—Acid salicylic, 1 drachm.  
Precipitated sulphur, 5 drachms.  
Vaseline, 3 ounces.

Make into an ointment, and before using place the affected part in hot water for several hours, adding one ounce and a half of powdered borax to each gallon of water used. The skin should be well dried before the salve is applied.—*L'Union Médicale*.

### PERSISTENT DANDRUFF.

Mr. Stephen, writing to the *Lancet*, says the following is very useful in persistent dandruff:

R Resoacini,  
Ol. alivorum,  
Ætheris sulph., aa ʒijj.  
Supt: vini. rect., ʒvjss.

To be well shaken and applied to the scalp by a bristle brush about twice as large as the ordinary mucilage brush, by insinuating it with the locks of hair. The head to be well washed with soap and warm water twice a week.—*Weekly Medical Review*.

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MONTREAL, JANUARY, 1891.

## TO OUR EXCHANGES.

Owing to the smallness of the type used in addressing some of the exchanges sent to us many of them have gone astray. As we value our exchanges highly, and keep many of them on file, this is very annoying. The only remedy we can suggest is to have the addresses printed in large clear type.

## LIABILITY OF THE JEWS TO CANCER.

It was stated recently by a leading Rabbi in the course of a lecture on the Jewish laws concerning diet that owing to their abstinence from pork, the Jews enjoyed a special immunity from cancer. On referring, however, to statistics which we have just received from Washington we learn that this is not the case. On page 15, table xi, we find that of 1000 deaths among Jews there were 13.58 due to cancer for males and 21.65 for females, while for the whole of the United States the death rate was 13.09 for males and 23.59 for females. So that the statement above made does not seem to be borne out by facts.

## THE KOCH TREATMENT.

In reading over our exchanges during the last month or more, the prevailing topic both of original communications, correspondence and of editorials, has been Koch's remedy for consumption. At first the enthusiasm knew no bounds. Everybody seemed to be going mad over Kochism. Several thousand physicians suddenly abandoned their lucrative practices to visit Berlin in order to learn the method of manufacture of the wonderful golden brown curative fluid. Even consumptive patients who could afford it, like drowning men grasping at a straw, braved the dangers and hardships of a winter trip to Berlin in order to avail themselves of a last hope for life. The results have been both disappointing and encouraging. Disappointing to the patients who were far advanced in phthisis pulmonalis, for in these cases the remedy has been worse than useless, but encouraging to those in the early stages of that disease, for marked and decided benefit has been obtained in many cases. In lupus the lymph has shown a virtue beyond all precedent, and in those hospitals where it has had a fair trial no one disputes its wonderful effect. As to whether this effect will be permanent or not time alone can reveal. Again, in local tubercular affections, although by no means invariable, the results have been encouraging. We venture to predict that in twenty years at most it will be generally recognized that consumptives must be isolated as long as bacilli can be detected in the sputum, just as much as the small-pox patients are now isolated as long as crusts are coming off their bodies. Neither would this sure and only means of stamping out the disease involve such hardships as would at first appear to be necessary. It is rather a matter of dollars and cents than personal hardship. Let the Federal Government of every country build and equip sanitarium in the most suitable part of its dominions capable of affording a comfortable home for every known consumptive in the

country, and invite or compel every one in an infective condition to reside there free from expense or as expensively as the rich may wish. This would not involve absolute isolation of one's friends, as in the case of small-pox, for during the whole summer consumptives even in the last stage might freely mingle with their friends in the open air without any danger. It is only when the consumptive is boxed up in a warm room with a healthy person that the latter is apt to acquire the disease, so that in our opinion the whole question is whether it is worth while spending money to stamp out the disease, and if so, whether the representatives of the people will decide to spend it. In a country like the United States, where hundreds of millions of dollars are squandered, there should be no trouble about obtaining two or three million dollars a year for a sufficient number of years to completely stamp out the disease. Whenever, by treatment or otherwise, the sputum of a given case ceases to reveal the presence of bacilli under the microscope then that patient might safely return to his family and friends. Moreover this would only be doing systematically what thousands are doing in a dangerous and desultory manner by going away for the benefit of their health to California or Colorado; but for everyone who is benefited by that trip we venture to say that at least one more healthy person contracts the disease. Imagine a non-consumptive person in a run down condition going for a pleasure trip and being shut up for a week in the same section of a Pullman car with a consumptive person who is giving out millions of tubercle bacilli from his lungs per hour. We feel it our duty to insist, in season and out of season, on the importance of recognizing the infectious nature of this disease. A letter, published in this issue, from Dr. G. T. Ross, Professor of Physiology in Bishop's College, now investigating the Koch remedy in Europe, will be found interesting.

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### DR. ALBERT P. SCOTT.

As we go to press we are under the painful necessity of chronicling the death of Albert P. Scott, C. M., M. D., (Bishop's, '87), L. R. C. P., Lond., Professor of Anatomy in the University of Bishop's College, who succumbed to an acute attack of pleurisy on Friday last, the 16th inst. A more lengthy obituary will appear in our next issue.

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### BOOK NOTICES.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS, Consisting of Original Treatises and Reproductions in English, of Books and Monographs selected from the latest literature of foreign countries, with all illustrations, etc. Contents: Insomnia and its Therapeutics. By A. W. MacFarlane, M. D. Index to volume vii. Published monthly. Price, \$10.00 a year, single copies, \$1.00. September, 1890. New York: William Wood and Company, 56 and 58 Lafayette Place, 1890.

### NEWS ITEMS.

The Civil, Military and Naval Departments of the British Government are supplied with the Fairchild Digestive products, and the Fairchild preparations for the predigestion of milk, etc., are especially preferred in India.

We have much pleasure in calling the attention of our readers to the advertisement of the Davis & Lawrence Company on another page, especially with regard to their menthol plasters. Although we have not used these ourselves, we have heard sufficiently of them from reliable sources to be warranted in recommending them for trial in general practice. Menthol, as is well known, has a soothing, quieting influence upon the motor, sensory and reflex nerves of the spinal cord, and thus lessens irritation. On account of the effects of the ordinary modes of applying menthol, it is now offered in the form of a plaster. In this it is combined with medicinal gums, and produces an agreeable sensation on application. It is highly recommended for speedy and effectual relief of neuralgia pains in intercostal, facial, bracial or other neuralgias and even placed over the pit of the stomach for gastralgia, it is said to act like a charm. In order to meet the requirements of practitioners, it is put up in rolls one yard long and seven inches wide, which can be cut into seven plasters, and is sold at \$1 a yard,