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THE

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OF

MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

EDITED BY

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A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

Original Communications.

NOTES FROM CASES OF ABDOMINAL SECTION, WITH REMARKS.*

BY H. MEEK, M.D.,

Fellow of Brit. Gyn. Soc., Eng., and Gynæcologist to
London Gen. Hosp., London, Ont.

CASE I.—Dermoid cyst of left ovary with small
dermoid cyst in right ovary.

Patient referred to me by Dr. Moorehouse,
London, January 28th, 1893, single, æt. 29 years,
had been suffering for past five years from back-
ache, tired feeling and pain in left inguinal region,
pain in side worse when at stool and walking; ;
menstrual periods every three and a-half weeks,
and flow more than normal.

She had consulted Dr. Moorehouse two years
previous, when he made a pelvic examination and
found a lump low down on left side of uterus,
which he thought was a large ovary. She then
consulted another physician, who examined and
told her she had a myoma of uterus, and used
electricity for a time, with no benefit. She again
returned to Dr. Moorehouse, during the autumn
of 1892, when he found lump had increased some
in size. He strongly advised operation, and re-
quested to have me examine patient with that
view.

On January 28th, 1893, I examined and found
abdominal examination negative. *Per vaginam*—
Uterus forward to right side—enlarged—sound
enters three inches, and blood follows removal of
sound. Behind and to left of uterus a lump
could be felt about as large as a good-sized orange
—elastic, but not fluctuating; close to uterus it
felt harder, and was somewhat tender on pressure;
uterus moves with movement of tumor. It ap-
peared to be closely connected with uterus by
short pedicle.

*Read before the Ont. Med. Association, June, 1894.

Per rectum.—It was tender on pressure. The
right ovary could not be felt at this examination.
Diagnosis was between dermoid cyst of left ovary
and myoma.

Operation February 7th, 1893, in City hospital;
anæsthetic by Dr. Balfour, and assisted by Dr.
Moorehouse, I made a rather long median in-
cision. Abdominal wall was vascular. Explora-
tion with fingers:—I found lump to be a semi-
solid mass of left ovary, adherent in pelvis, and
connected with uterus by a broad, thin, short
pedicle. After separating adhesions, I lifted up
tumor and plunged in a trocar, but contents,
which were found to be sebaceous matter, hair
and bone, would not, of course, run through.
The contents were then pressed out through the
opening made by trocar, being careful to prevent
any getting into peritoneal cavity. Pedicle was
then easily transfixed and ligated, and sac re-
moved. The other ovary was found to be en-
larged and cystic, and was therefore removed with
the corresponding tube. Pelvic cavity was sponged
out and abdomen closed without drainage. Re-
covery was uneventful. Right ovary was found
to contain, besides a multilocular fluid cyst, a
small dermoid cyst about as large as a hickory
nut, the contents of which were sebaceous matter,
hair and skin.

Remarks.—(1) A point to which I wish to
direct attention in this case, and I presume it will
apply to all cases of dermoid cyst of ovary where
the tumor is wedged down in pelvis, is the diffi-
culty of making a differential diagnosis, more
particularly from myoma. The slow growth, the
feel, the close connection with uterus, with en-
largement of that organ and increased flow at
menstrual periods, would quite easily mislead one.
A myoma, however, is not usually tender on pres-
sure, unless patient has had pelvic peritonitis, and
the uterus as a rule, with myoma, is larger than
it would be with dermoid cyst of same size.

(2) I think I have read somewhere in the ex-
perience of others, what in my own experience I
have frequently observed, viz., that all tumors
having a close connection with uterus, whether
ovary, tube or broad ligament, and no matter
whether fluid or solid, are usually accompanied by
enlargement of uterus with increased flow at
menstrual periods.

(3) With regard to frequency of dermoid cysts

of ovary being double, Doran in his work on "Tumors of Ovary and Broad Ligament," states, "that out of thirty-one cases of dermoid tumor of ovary he had seen, seven were double. Out of six or seven cases I have seen myself, this was the only case in which both ovaries contained dermoid cysts.

CASE II.—Hæmatosalpinx or ruptured tubal pregnancy of left tube, with encysted hæmatocele behind broad ligament, complicated by ventral hernia in cicatrix, following a previous abdominal section for tubal pregnancy of right side.

Patient referred to me by Dr. Weld, London, æt. thirty-seven years, married nine years, no children and no certainty of ever having been pregnant. Menstrual periods appeared at thirteen years, were regular and normal till æt. 19 years, when she began to suffer from painful menstruation. When æt. twenty-three years she had cervix dilated by Dr. Sinclair, of Manchester, for dysmenorrhœa, and wore a stem pessary for a time. Following this operation she suffered much less pain at periods.

Some years later, while nursing in Manchester hospital, she had an attack of pelvic inflammation which confined her to bed for three months. She enjoyed very good health for some time after this illness, though not free from pain at periods. Dysmenorrhœa got worse after coming to America seven years ago. The pain was of a crampy nature, and usually on first day of flow. In 1887 she had cervix dilated by Dr. Howitt, of Guelph. Some time after this she again consulted Dr. Howitt with some symptoms of pregnancy. She had not missed a period, but flow had been scanty. Soon after this she had a profuse flow with clots and pain, and thought she had a miscarriage, though neither fœtus nor placenta were seen. After this, periods were quite regular for a time again.

During spring of 1889, periods again became scanty, and about first week in July following she was taken rather suddenly with severe crampy pains without flow and without syncope. She again consulted Dr. Howitt at this time, who from examination suspected ruptured tubal pregnancy, and advised operation. She went into Guelph hospital, and on July 8th, 1889, Dr. Howitt operated, and removed what in a letter to me, he says, "he had every reason to consider a ruptured

tubal pregnancy of right side." He also states in this letter that "at time of operation the left ovary and tube appeared to be perfectly healthy, and were not removed." A drainage tube was used at this operation. She made a very satisfactory recovery, with exception of an abscess in abdominal wall three weeks after operation.

Since operation menstrual periods have been regular every four weeks, but painful. Soon after abdominal wound healed, she noticed a small lump at lower extremity of cicatrix when standing, rather painful, and larger on coughing or sneezing. This lump has been gradually getting larger. She also complained of great irritability of bladder at times.

Examination of abdomen.—I found cicatrix of old abdominal wound considerably widened out, and at lower end a protrusion two inches across by one inch deep, and one inch from above down. It had a soft doughy feel like omentum, and was readily reducible into abdominal cavity through an opening one half inch wide by one inch in length.

Per Vaginem.—Uterus was found to be forward and to right, partially fixed, not enlarged, and os not much open. Right fornix was free, but on left side low down behind was a lump about as large as a small sized orange, tender on pressure, not movable. It was somewhat elongated and not fluctuating. This lump I took to be distended left tube and ovary.

She had menstruated with less pain than usual, two weeks previous to this examination. Following this examination she menstruated again about April 10th for four days; flow not profuse and not much pain. She menstruated again May 8th for three or four days, and had very little pain.

Operation Saturday, May 13th, 1893, in City hospital. Chloroform by Dr. Balfour, and assisted by Dr. Weld, I made incision in line of old cicatrix down through cicatricial tissue. Omentum was found adherent along the whole line of cicatrix. At lower end recti muscles were found separated two and a half inches, coming gradually together at upper end.

After separating adherent omentum, I explored pelvis, and found stump on right side clean and smooth, on left side a mass nearly as large as my fist, low down, adherent to floor of pelvis, omentum and intestines. The adhesions were separated

with some difficulty. In lifting up the mass, I broke into an encysted collection of dark fluid blood and clots behind broad ligament. The distended tube coiled around an enlarged, degenerated, cystic ovary was then lifted up and ligated close to uterus and cut away. After tying several bleeding points in omentum the pelvic cavity was carefully sponged out, and abdominal wound closed by through and through silk worm gut sutures, after splitting recti and turning out flaps so as to bring together from each side a broad, raw, muscular surface. The abdomen was closed without flushing or drainage. Recovery was uninterrupted. The abdominal sutures were left in over two weeks, and there was no sign of irritation about any of them when removed. There has been no recurrence of the ventral hernia since. The tube was found on examination to be distended with dark fluid blood; its fimbriated end closed, but uterine orifice open.

Remarks.—Although neither fœtus nor placenta were found at my operation, and though Dr. Howitt did not state in his letter to me that either fœtus or placenta had been found at his operation, yet I am inclined to think that the condition of things found at each operation was the result of ruptured tubal pregnancy. The encysted collection of blood behind broad ligament in my operation is, I think, strongly in favor of this view.

It is interesting to notice, that when Dr. Howitt operated for removal of right tube, the left ovary and tube were apparently healthy; and this brings up the question which has frequently been under discussion before, as to whether, in an operation for removal of ruptured tubal pregnancy of one side, it is right to leave behind in the pelvis the opposite apparently healthy appendage. I think it is generally acknowledged that tubal pregnancy is likely to recur in the opposite tube if left. In one case, reported by Tait, with which most of you are familiar, a normal pregnancy in uterus intervened between operation for ruptured tubal pregnancy on one side and interstitial pregnancy on the other. With this experience before him I have seen Tait leave the opposite tube in a case in which I assisted in the operation for ruptured tubal pregnancy.

In the case I have reported, the patient was very anxious for children and did not wish, if it

could be avoided, to be deprived of the possibility of becoming pregnant, so that under these circumstances, I think Dr. Howitt was justified in leaving the opposite tube and ovary.

In connection with this case, I have just one word to say on the subject of flushing and drainage. A few years ago I would have considered it unsafe to close the abdomen in such a case without drainage, but it is just such cases that teach us that the closed peritoneum can dispose of a little blood, etc., that may be left, much better than if we should flush and drain. Drainage in this case would probably have interfered with the result desired, viz., cure of the ventral hernia.

Case III.—Suppurative appendicitis and peritonitis acute. Incision and drainage, followed twenty-three days later by discharge of gangrenous appendix through abdominal wound.

On Saturday, January 13th, 1894, I was called by Dr. Cline, of Belmont, to operate on a case of suppurative appendicitis. Patient, young lady æt. nineteen years, living on a farm near Belmont, was taken ill on Tuesday previous with abdominal pain and vomiting. Dr. Cline saw her on Wednesday and gave her a laxative dose of castor oil and opiates to ease pain. Bowels moved well from oil, and next day, Thursday, she felt very much better and got out of bed. Friday she was worse again with more pain, and rising pulse and temperature. Saturday, a.m., temperature 102° F., pulse 120.

With Dr. J. B. Campbell, of London, I arrived at house about 3.30 p.m., and found temperature 102° F., pulse 160; sick stomach. She was partly under the influence of opiates so that she was not at the time suffering much pain. Abdomen was distended and tympanitic. An indistinct thickening could be felt in region of appendix. From condition of patient immediate operative interference was called for. Chloroform administered by Dr. J. B. Campbell, and assisted by Dr. Cline, I again examined under anesthesia before operating. Through abdominal wall thickening could be felt somewhat more distinctly.

Per Vaginem.—A mass could be felt to right of retroverted uterus in location of right Fallopian tube. I made an incision through abdominal wall just inside of spine of ilium about three inches long, down through muscles and fascia to peritoneum.

Before going further, I again examined with

finger of one hand in vagina and finger of other hand in wound, and from location of mass I was in some doubt as to whether it might not be distended right Fallopian tube. There was no bulging of peritoneum into wound, and percussion at this point was tympanitic. I then separated peritoneum from abdominal wall, down and back behind cæcum, to ascertain if there was any tense point where it would be safer to open. I could not find any tense point, however, though I separated as far in as brim of true pelvis. I then opened through peritoneum at point just inside of spine of ilium, when out gushed about half a pint of sero-purulent fluid, having a strong fecal odor. I then explored carefully with finger, but could not feel that peritoneal cavity was shut off in any direction. I did not deem it advisable to hunt too much for appendix, and thought the patient's chances would be better from free drainage than from prolonged operation and spreading of septic fluid, which hunting for, and removal of, appendix would necessitate. I, therefore, sponged out cavity and introduced rubber drain tube and gauze down behind cæcum, and sutured external wound above and below drain tube.

After operation, patient rallied very well, but was restless and vomited considerable coffee-ground material during night.

Next morning, January 14th, temperature 101° F., pulse 140; 15th, temperature 100½° F., pulse 126; 16th, temperature 100° F., pulse 100, free discharge from wound, fecal odor. From 16th till 24th, temperature ranged from 99½° to 101°, pulse from 100 to 108; wound discharging a moderate amount of thick pus; stomach weak, and patient nourished mostly by nutrient enemata. Very restless and slightly delirious at times, but does not complain of pain. Evening of 24th, a profuse discharge, having a strong fecal odor, and containing a quantity of fat globules and bubbles of gas, came up into wound from outside of peritoneum at upper angle of wound. A probe could be passed through this opening into a large abscess cavity extending down behind cæcum and up towards right kidney. The abscess cavity was washed out twice daily with iodine water; with little effect, however, on discharge, pulse or temperature; the temperature ranging from 101° F. to 103° F., and pulse 104 to 112.

January 29th, I made a counter opening in loin

under attempted anæsthesia with ethyl chloride, and introduced a rubber drainage tube from front opening through back and washed out through this. From this time on till February 5th, condition continued about the same, though cavity was washed out freely twice daily.

On February 5th, just twenty-three days after operation, Dr. Cline found a slough presenting at front extra-peritoneal opening. With forceps he made traction and removed a gangrenous mass between two and three inches long and about the thickness of my thumb, having a very offensive odor. This mass was not examined very carefully, but it, no doubt, was the gangrenous appendix which had sloughed off and worked up into opening with flushing of abscess cavity. From the time slough was removed, all symptoms improved and abscess cavity gradually diminished in size.

Remarks.—(1) This case was a good example, showing the difficulty that may arise in some cases of appendicitis in the female, of distinguishing the swelling felt *per vaginam* from distended right Fallopian tube.

(2) Considering the tedious and stormy convalescence in this case, I think, perhaps, it would have been better to have opened into peritoneal cavity higher up near median line, and have gone right down after appendix and removed it at first. In doing this, I would have run risk of general peritoneal infection, but such risk could hardly be greater than risk from leaving gangrenous appendix to find its way up into wound. The higher incision would certainly be the proper one if one could be sure the appendix was gangrenous. In emergency cases of this kind, however, under the influence of opium, I do not see how it is possible to tell that the organ is in a state of gangrene. There are other circumstances that influence the surgeon in what he does in these cases. In this case, I had to operate without much preparation, in a country farm-house, by lamplight, with very little assistance, a neighbor lady holding the lamp. The patient's pulse was rapid and weak. Under such circumstances, with an abdominal incision higher up and removal of appendix, the result would, no doubt, have been rapidly fatal or rapid recovery.

(3) I think convalescence might have been considerably hastened if, on January 24th, eleven days after operation, when extra-peritoneal

abscess broke into wound, the patient had been anaesthetized and a free opening made in loin and cavity explored. The sloughing appendix could then probably have been removed and cavity cleaned and drained. This is what I would have preferred doing, but one cannot always do what one prefers.

CASE 4.—Tumor of pylorus and duodenum causing stricture; Gastro enterostomy with Murphy button; Recovery.

Patient, male, æt. fifty-eight years, laborer, had syphilis forty years ago.

Health good till June, 1893 when he entered city hospital suffering from abdominal pain, vomiting, loss of flesh. Diagnosis at that time was probable malignant disease of pylorus. Under treatment, washing out stomach and diet, he improved and went out of hospital some time during summer. Readmitted October, 1893. Condition on readmission—emaciated cachectic appearance, vomiting after food, pain in abdomen around navel and epigastrium.

Examination of abdomen; flatulent distension; tumor with rather hard feel apparently involving pyloric end of stomach; stomach dilated; liver slightly enlarged. Examination of contents of stomach: could find no free hydrochloric acid, but lactic acid found one hour after food. Lymphatic glands in groin, axilla and neck also epitrochlear, enlarged.

Diagnosis.—Malignant disease of pylorus producing stricture. Liquid nourishment would pass through pretty well, but solid food would remain in stomach and could be washed out several days after taking. The possibility of tumor being specific was considered. Under treatment by washing out stomach, diet, etc., there was no improvement. Antisyphilitic treatment appeared to benefit some.

In April, 1894, consultants decided in favor of exploratory incision with permission to do gastro-enterostomy if thought advisable. I was asked by attending staff physician, Dr. Logie, to take charge of case and operate. Directions were given to keep patient on peptonized milk by stomach and nutrient enemata for several days before operation. Stomach to be thoroughly washed out morning before operation.

Operation Monday, April 23rd, 3.30 p.m. Notwithstanding preparation the abdomen was

distended and flatulent. Intestines had not been well cleaned out. Anæsthetic by Dr. Balfour, and, assisted by Drs. Eccles, Logie and McGregor, I made median incision from ensiform cartilage down to left of umbilicus. There was some fluid in peritoneal cavity, but no peritonitis. The somewhat enlarged left lobe of liver, distended transverse colon omentum and coils of small intestine presented in wound. By pushing intestines down, somewhat dilated stomach presented. A tumor nearly as large as my closed fist was found involving pyloric end of stomach and duodenum. This tumor was irregular in outline, but smooth and not nodular.

Anastomosis of stomach with small intestine was decided on. A coil of small intestine from near left kidney as high up in jejunum as possible was selected and brought up in wound. Stomach was also drawn up in wound. The omentum was torn through and posterior surface of stomach wall, which was thicker than normal, brought up into wound. Points for approximation were selected, and, with fine triangular needle and a rather fine silk thread, I introduced running suture in stomach and another through coats of intestine after the method described by Murphy. An opening was made in intestine between running suture. Contents having been pressed out and held back by assistant Dr. Eccles, the smaller half of button was inserted in opening and held by assistant while pouch string was tightened around cylinder and tied. There was some delay in doing this caused by tendency of mucous coat to roll out, and also by bleeding from small artery, though opening had been made in gut at a point opposite the attachment of mesentery. Opening was then made through wall of stomach, and larger half of button inserted and held by assistant Dr. Logie, while running thread was drawn up around cylinder and tied. The halves of button were then pressed together. A couple of Lembert sutures completed the approximation.

During the introduction and fixing of button, the field of operation was shut off from abdominal contents and coils of small intestine outside abdomen by warm, moist towels and gauze pads. The approximated stomach and jejunum with omentum and intestine outside were carefully cleansed, and returned into abdomen with considerable difficulty on account of distension and

straining of patient. Abdominal wound was sutured with interrupted silk worm gut sutures and dressings applied.

Patient put to bed in very good condition with instructions to be fed by stimulant nutrient enemata and warm water enemata for thirst. There was almost incessant regurgitation from stomach for several days after operation. Peptonized milk and liquid peptonoids were allowed by stomach about end of second day. Liquid regurgitated consisted of bile, mucous, blood, and partially digested fluid swallowed.

On third day he brought up a piece of orange pulp and when asked about it he said he had eaten part of an orange on Wednesday of the week preceding the operation. It had evidently remained in stomach and had not been washed out in the preparatory washing.

Bowels were moved with enema on fourth day without relief of regurgitation. Opiates were given with little relief. He continued to regurgitate and hiccup, bringing up two thirds of what he swallowed. Temperature kept normal and pulse good, from 70 to 80. On fifth day I tried hydrarg. per chlorid gr. $\frac{1}{16}$ by mouth every hour, when regurgitation quite rapidly lessened and completely ceased inside of thirty-six hours, and did not return after. From fifth till tenth day he had some elevation of temperature at times from stitch hole abscess. All abdominal sutures were removed on 8th day, and the stitch hole abscess quickly healed after this.

During slight elevation of temperature on fifth day, he got out of bed on his feet when nurse was not watching. Again on the ninth day when nurse was not watching, he got out of bed and dressed himself and walked from his room through long ward to closet and had motion of bowels there and was on his way back when discovered. He was light-headed from temperature at these times. This little exercise apparently did not affect him in the least. All the stools with exception of one passed in closet on ninth day, have been carefully examined with no sign of button as yet.

He has been up and about since third week, and is taking both solid and liquid food with very little discomfort. His appetite is good; bowels move regularly. He sleeps well and says that he suffers much less pain than before the operation.

He has been taking hydrarg per chlorid ever since it was commenced on fifth day after operation, but less frequently now.

Examination of abdomen.—It is difficult to feel tumor.

Remarks.—There are several interesting things in this case:

- (1) The rapid lessening and cessation of regurgitation after commencing bichloride.
- (2) The apparent disappearance of tumor, and reduction of enlargement of lymphatic glands.
- (3) Has the button passed or is it still in place? I would like to know, but probably never will during patient's life.

TREATMENT OF ENDOMETRITIS.*

BY HERMAN E. HAYD, M.D., M.R.C.S.E., BUFFALO, N.Y.

Mr. President and Gentlemen.—The pathology of pelvic inflammation teaches us that the endometrium plays the most important rôle in connection with the diseases of the uterus and its adnexæ. The lymphatics and cellular tissue, which so intimately surround the uterus, are, no doubt, frequently the channels of transmission of puerperal infection to the peritoneal cavity; but the vast majority of infective poisons find their starting point in the lining membrane of the uterus, and by continuity of tissue, extend to the tubes, ovaries, peritoneum and abdominal viscera. We are, therefore, confronted with the important practical question, how shall this inflammation be best treated? and what means shall be adopted to confine it to the uterus, or at all events, lessen its disastrous effects upon the adjacent and contiguous structures?

All intra-uterine manipulations are associated, necessarily, with some degree of danger, and a simple and benign endometritis, or better, metro-endometritis, or even metro-endo-salpingitis, may, by reason of such treatment, assume active and dangerous intensity. Moreover, it must always be borne in mind, these conditions are often due to, and dependent upon, some general systemic condition, as gout, scrofula, syphilis, simple but prolonged anæmia, bad hygiene, social and sexual excesses, etc., and require no local treatment

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whatever, and are often relieved and even cured, by proper constitutional measures. But, unfortunately, metro-endometritis is often a very chronic and intractable disease, and if not cured, is capable of extending its mischievous effects upon so many important structures, that, in addition to constitutional agents, local and topical applications become absolutely necessary.

We may classify endometritis into acute, sub-acute, and chronic; and, according to its location, into cervical and corporeal. True, this is but an arbitrary and conventional classification; yet it embraces all the clinical features, as well as the pathological conditions assumed by the disease, whether of puerperal, post-puerperal, gonorrhœal or traumatic origin; or whether a simple catarrh, granular, fungus, or ulcerating process.

Acute endometritis or pelvic inflammation is treated as one would treat other inflammatory conditions: rest in bed, opium or codeia for the pain, hot fomentations to the lower abdomen, and hot vaginal douches, if soothing, grateful and well borne, a nourishing but simple diet, and daily soluble movements of the bowels, if possible. A brisk cathartic at the onset of the attack is often capable of aborting what might have been a very pronounced peritonitis. If an acute specific cause can be demonstrated, as for instance, gonorrhœa, decomposing detritis after abortion or labor or trauma, the result of criminal attempts at abortion—under the strictest antiseptic precautions the uterus should be thoroughly dilated, washed out with a weak corrosive sublimate solution 1.5000, and curetted with a sharp spoon; and then again irrigate the vagina and uterus thoroughly and leave in the uterine cavity a suppository of iodoform. This I have repeatedly done, and invariably have lessened the pain and distress, reduced the temperature and pulse, and I am satisfied, shortened and sometimes aborted the course of the disease.

There is no place in surgery where this great surgical principal of drainage is more indicated than in these cases, because they manifest the greatest tendency to chronicity, and are associated with such dangerous complications and irreparable mischief to the tubes and surrounding tissues. By its timely employment, life can often be saved, and the usefulness of important structures maintained. I am inclined to believe that intra-uterine

injections are unnecessary if this procedure has been carefully carried out; and, consequently, the dangers and pain due to the frequent handling of the parts are minimized.

The treatment of subacute and chronic metro-endometritis is more elective; consequently, there are many different methods of procedure, and each one accomplishes more or less good, according to its applicability. If there be a pronounced laceration of the cervix, with ectropion of the lips, and a persistent and recurring ulceration, a properly performed Emmet, preceded by curettement, will give the greatest satisfaction; and in fact, if the chronic inflammation and hypertrophy be due to sub-involution, consequent upon the laceration, nothing short of this operation will cure the case. Applications to the endometrium of Churchill's tinct. iodine, or two parts iodine to one of carbolic acid, or a strong solution of nitrate of silver. Painting the vault of the vagina and cervix with iodine, and well applied tampons saturated with glycerine or boro-glyceride 30%, or ichthyol 15%, with glycerine are also indicated. It is also in this class of cases where galvanism intra-uterine is so signally beneficial, and why there can be any doubt as to its efficiency, is a growing surprise to me. Malpositions and displacements must also be corrected, if possible, by proper filling passages.

In making applications to the endometrium, one important point must always be borne in mind. Be as aseptic as possible, and be certain that the internal os is patulous, so that the fluids and discharges can find egress; as drainage must be provided for, otherwise colic, pain and a slight or even a very severe peritonitis can result from these trivial and apparently harmless applications.

Endometritis is not usually an uncomplicated affection, but the inflammatory process has extended to the tubes and ovaries and peritoneum. Fixation of these important structures has taken place, and their secretions are retained. Now comes the important question, Is the endometritis, which was responsible for the salpingitis and ovaritis and peritonitis, the point of surgical attack, or has it ceased to be an important factor when the tube and ovarian mischief can, with reasonable certainty, be felt and diagnosticated?

Naturally, the more the source of irritation be endometrial, the more we can expect from local

and conservative treatment, while, on the contrary, if tubal and ovarian disease exist to any great degree, ablation of the offending organs, is, perhaps, the only hope of relief. As a result of these premises, two great schools of pelvic surgery have their existence, the one believing that endometritis seldom requires any special treatment other than good hygiene, absence of sexual relation, good food, and good environment, tonics and daily soluble movements of the bowels. In other words, ill-health and much suffering indicate not simply a condition curable by simple means, but serious tube and ovary mischief, curable by no means short of an abdominal section.

On the other hand, and I believe there is a growing feeling in the profession that conservative treatment is much more often called for, and that the endometrium is the seat of progressive mischief. About ten years ago, Dr. Gill Wylie brought to our notice his stem drain, which he introduced into the uterus after curettement, and, three years ago, Dr. William Polk emphasized that treatment by giving us his simple but very efficacious operation, and with it a report of a large and extremely interesting class of cases, in which there was considerable tubal and ovarian mischief, kept up and dependent upon endometritis.

So favorably has this method of treatment been received, that many operators have extended its range of usefulness, and first curette, and pack the uterus before doing a section, so as to get a perfectly clean field, and either complete the section upon the same day or a few days later. It is claimed, and I believe justly, that the great advantage of packing the uterus after curettage is that it stimulates quicker and more perfect involution; that it promotes more perfect and permanent drainage by insuring patency of the cervical canal; that it assists in the restoration of a misplaced organ by supplying a soft support as well as drain; and that the mucous walls of the uterus, being separated by the gauze, a healthy epithelium is soon produced.

I have seen the most inveterate cases of uterine leucorrhœa, metrorrhagia and painful menstruation cured by this simple procedure when a long course of uterine applications, fraught with infinitely more danger, had failed to bring about any permanent improvement. Cases, moreover, com-

plicated with considerable tubal and ovarian mischief and sterility, as well as general ill-health, have been speedily benefited; and maternal functions and responsibilities have been assumed, and future good health and happiness accomplished.

I prefer to do this operation in those ambulatory cases where there exists some tubal thickening, and where intra-uterine manipulations cause much pain and distress, believing that it is less dangerous to thoroughly clean the uterus, and provide suitable drainage at one sitting, than to subject the patient to the possible dangers of increasing tubal and ovarian trouble by too frequent intra-uterine medication.

Of course, I do not wish to be understood, that this operation is to take the place of the brilliant surgical procedure, salpingotomy and salpingo-oophorectomy; because nothing short of a laparotomy can cure a big pus tube with its accompanying ovarian abscess: but I do believe that tubal and ovarian inflammations, dependent as they often are upon endometritis and short of pus collections, are often cured by dilatation, curettement, and uterine drainage; and without adding a large element of danger either to the existing inflammations, or to the possibilities of remoter mischief.

THE IMPORTANCE OF EARLY ATTENTION TO THE DISABILITY CAUSED BY INFANTILE PARALYSIS.*

BY A. B. JUDSON, M. D., NEW YORK.

I propose to consider briefly the question whether a certain class of patients should not be committed more entirely and more early than they are to the care of the orthopedic surgeon, a consideration as interesting to the family physician as to the orthopedist, as they meet in a friendly alliance to secure the greatest benefit for their common patient.

I refer to patients disabled by infantile paralysis. The child has passed through the stage of onset, Ergot, electricity and massage have produced their legitimate effect, and we will say that the eighteen months, which are believed to be the limit of spontaneous recovery from the paralysis, are passed. The friends and the patient, with

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many grievous misgivings, have become reconciled, or at least accustomed, to disability and deformity which now seem to change for neither the better nor the worse. What can now be done? The question whether such a patient may not yet receive benefit from the advance of scientific knowledge, or from the daily increasing facilities for the application of knowledge, will surely spring up in the parental heart.

Now it is curious to note that the deformity in these cases is often found, upon analysis, to be a disability more than a deformity. Take a case, for example, in which the knee cannot be completely extended. When the patient is sitting there is no deformity, but when he stands, the apparent deformity is due to a disability—an inability to extend the knee. How easy it would have been to prevent contraction of the hamstrings by providing for their repeated elongation by complete extension of the knee, easy comparatively for one who has given himself to such details, and is habitually mindful of their importance, and free from the manifold cares which beset the average practitioner. And it should be borne in mind that cases sometimes occur in which shortening of the tendons begins, in a manner not well understood, at a very early stage, before simple desuetude can be fairly accused of being the author of the mischief. The prevention of muscular and tendinous shortening then should receive attention on the part of the early observer of the case. It is not an obscure and difficult point, but one which has perhaps escaped the consideration to which it is entitled.

To recur to the disabled knee, and this part of the anatomy is used simply as a convenient example to illustrate points in pathology, and treatment applicable to all the joints, if the knee is kept extended at those times when walking is attempted, not only are the muscles and tendons kept in normal elongation, but the general welfare of the limb is assured. Neglected patients may be seen in the streets walking laboriously with extension of the knee, produced by the hand pressed firmly at every step on the lower part of the thigh when the weight of the body is on that limb. It is doubtful whether this in any case prevents the final resort to a crutch, by the use of which the limb is made to dangle, being carried about as a worse than useless burden, twining

limp around the crutch, subject to the painful affections which attack the lower extremities in cold weather in the absence of healthy circulation, and more and more impeding locomotion until, as has happened many times, the adult patient seeks relief and improved locomotor ability in amputation and an artificial limb. If the knee is stiffened mechanically, the pressure of the weight of the body in standing, and the repeated concussion of the limb, as the foot strikes the ground in walking and running, will improve the tardy circulation, but beyond this, and better than this, will be the development of unused muscular fibres and special groups of muscles, by whose action important motions will be acquired which would have been impossible if the limb had remained in suspension.

Now in order to keep the knee firmly extended under the weight of the body in standing and walking, and to give use and development, as far as may be, to the fragmentary muscular system of the limb, apparatus is required; but it will not be obtained without authoritative medical advice and prescription, and as a rule the family physician cannot be expected to work out the tedious processes incident to treatment of this kind. It falls to the lot of the specialist, who can well bear the inconvenience attending final results which are more or less imperfect, after satisfying himself that he has done all that science permits to be done, and whose daily and hourly mastery of the necessary details has enabled him to reduce perplexing and complicating conditions to familiar routine. Treatment of this kind lies far outside ordinary practice in which the physician renders such signal service. He makes his diagnosis, advises, prescribes, remains on guard against complications, foresees the crisis and prepares for it, leads the way cheerfully through convalescence; and medical science, so dear to us all, finds but another illustration of its power and beneficence. In one home a wasting fever has been finally resolved and the patient rises in perfect, or even improved, health from a bed where the grim alternative has been decided in his favor. In another the children have been happily carried through the perils of infection and resume their places at the table. But in the special practice adapted to the cases under consideration there is no fear of a fatal result and no rejoicing, and the object

sought is at the best a palliation. But who will say that important service has not been rendered? For it should be remembered that the conservative and plodding practitioner along this line has for an ally one of the most potent influences in Nature in the growth of the body. The popular reliance on this force, expressed in the common question, "Will the child not outgrow the ailment?" whatever it may be, is not always misplaced. Happy the physician who, imparting his confidence to the patient's friends, and relying on the exact science of the physicist, sees grace and power growing out of deformity and helplessness.

A good general rule in the treatment of deformity in a growing child is to keep the part as near as possible in the desired shape as much of the time, day and night, as is practicable, so that the increment shall be on the right side of the dividing line between the normal and abnormal. The familiar proverb says: "As the twig is bent, the tree's inclined." In the troubles following infantile paralysis the principle should be extended. We should not only persist in keeping the part as near the normal shape as we can, but we should also give as wide play, as the crippled condition of the limb will allow, to the functions of motion and weight-bearing. From the very earliest attempt to walk, or to make use of the muscles and joints which are imperilled by the cord lesion, extraneous assistance should be afforded. It should not be said, off-hand, that the child is too young. The first and repeated question should be: Is the child not yet old enough, or is he not already giving sufficient evidence of a desire to make use of the questionable muscles and joints to make assistance desirable or necessary?

When efficient treatment is begun it is easily continued. Improved ability is at once appreciated by both parent and child. It is well that such is the fact, for improvement does not stop with infancy or childhood. The process is slow and prosaic, but the benefit cannot be over-estimated in the opinion of the one who is in the best position to judge of its value. A slight improvement in the gait or an ability to walk a little faster, or a little further without fatigue, confers lasting happiness, and the patient and physician are thus encouraged to go on to new achievements until, with one step after another gained, the outcome is an adult well able to follow the ordinary pursuits of life, in place of a being who had looked forward to hopeless dependence.

Selected Articles.

CLINICAL STUDY OF THE SO-CALLED REFLEX NEUROSES.

Observations gathered mainly during the last fifteen to twenty years, by numerous authors, have shown that there are many nervous ailments which owe their origin to a minor local disease or anomaly in some part of the body. Yet this subject of reflex neuroses has neither received adequate recognition in general text-books, nor has it been fully appreciated by the profession at large. The interest of such a subject to the general practitioner depends upon the frequency of these ailments. In this respect views differ widely.

Ophthalmic and rhinologic observers have, perhaps more than any other, contributed to this subject, and their reports abound in instances of this kind. Indeed some specialists no doubt exaggerate by including under the head of reflex neuroses, conditions, the reflex origin of which is not yet established nor even probable. Many text-books on nervous diseases, on the other hand, slight the subject, or like the treatise of L. C. Gray, state that reflex neuroses are rare occurrences. Yet even widely different views as to the frequency of reflex neuroses are not wholly irreconcilable, if we but use the term with strict definition of its meaning. According to gradual usage the name, "reflex neuroses," is at present applied to any *abnormal* nervous process started by the irritation of some peripheral sensory area. This definition by itself enables us to distinguish between mere symptoms which are the *normal* and invariable consequences of disease of a given sensory part, and the reflex neuroses proper which are brought on by such irritation only under certain circumstances. In fact, characteristic of reflex neuroses is their apparent capriciousness. The same peripheral lesion which leads to a reflex neurosis in some patients may exist in others without producing such disturbances.

It is evident that if we accept this definition, very many headaches, neuralgias and motor disturbances come under the head of reflex neuroses, and that this nosological group hence includes many of the ailments daily met with. On the other hand, it may be admitted that epilepsy, chorea and other types of nervous disease of graver significance are probably but rarely of reflex origin.

The term "reflex" is used by the clinician in this connection in a wider than its true physiologic significance. As the physiologist speaks of the act of winking as a reflex produced by conjunctival irritation, so the clinician may call

a blepharospasm a reflex neurosis, if it is maintained by conjunctival disease. But to speak of a neuralgia due to a diseased tooth as a "reflex" occurrence, is not warranted by physiologic nomenclature. We must either intentionally enlarge the significance of the term "reflex," or we may call these nervous disturbances, *neuroses of peripheral origin*, and subdivide them into motor, secretory, vaso-motor, sensory, (and possibly inhibitory) neuroses of peripheral origin. Even the motor "reflex" neuroses are not always reflex in the sense of the physiologist. Some of them, it is true, are but types of normal reflex action morbidly exaggerated. As such might be mentioned sneezing fits from nasal disturbances and blepharospasm from ocular irritation. In other instances, however, such as asthma and reflex epileptiform convulsions, the nervous disturbance has no physiologic prototype. Unlike the normal reflexes, these motor phenomena are not the immediate consequence of the irritation to which they owe their origin. The peripheral excitation does not lead at once to a reflex action, but its continuance influences the nervous centres so that *periodic* discharges occur in the nerve channels which are normally not open to impulses of such origin. *Periodicity* is also a feature of some sensory neuroses, like migraine and the so-called visceral neuralgias. Other sensory neuroses, however, such as many forms of headache and neuralgia, are either constantly present, or recur with every increase of peripheral irritation.

In order to have a definite basis for further discussion of the subject, I will now tabulate the neuroses of peripheral origin, the existence of which has been satisfactorily established by the observations of more than one author. Without attempting any full review of the literature, I will only quote as authorities some of the writers who reported either the first or the most conclusive instances of such neuroses, or who have summarized the literature. I may add that I have personally seen illustrations of nearly all the quoted neuroses of ocular and nasal origin.

STARTING POINT.	NEUROSIS.
Anomalies of refraction and accommodation of the eye and some instances of anomalies of the external muscles.	Headaches, continuous or periodic. Vertigo. Nausea. Ciliary spasm. Blepharospasm and chorea of facial muscles. Epilepsy (rare).
Diplopia from insufficiency of one of the external muscles of the eye.	Deviation of the head, simulating wry-neck.
Nasal disease and suppuration of maxillary sinus.	Lachrymation. Discomfort in eyes and lids. Scotoma fugax (blind headache). Vaso-motor disturbances of lids and face. Headaches. Neuralgia of branches of trigemimus. Vertigo. Facial spasm. Cough. Spasm of glottis. Asthma. Nightmare. Epileptiform convulsions. Functional cardiac disturbances. The symptoms of exophthalmic goitre.

STARTING POINT.	NEUROSIS..
Ears.	Vertigo. Nystagmus. Cough (rare).
Pharynx and faucial region.	Cough. Epilepsy. Spasm of glottis. Morning vomiting.
Teeth.	Neuralgia of trigemimus. Otagia. Headaches. Facial spasm. Epileptiform convulsions.
Stomach and intestinal tract.	Headache. Vertigo. Trigemimus neuralgia. Visceral neuralgias. Cardiac and circulatory disturbances. Epileptiform convulsions.
Painful peripheral cicatrices.	Epilepsy.

This list would be incomplete without reference to neuroses originating from disease of the pelvic organs and the male genitals (especially adherence of the prepuce). But since I have no personal experience in this line, and since authors on these subjects are neither as precise in their statements nor as harmonious among themselves as in the instances tabulated, I will base my comments principally on the other topics.

The co-existence of a peripheral anomaly and of a functional nervous ailment is not sufficient by itself to base upon it the conclusion that the latter is dependent upon the former. The reflex origin of a given neurosis can, however, be proven by various methods. In many instances it is suggested by the patient's history if carefully examined. Whenever the nervous disturbance follows regularly any intensification of pre-existing local ailments, a relationship between the two phenomena is highly probable in the light of our present information. If the patient states that his headache is brought on by the use of his eyes, or in another case that his attack of asthma is always preceded by sneezing and stuffiness of the nose, there can be little doubt as to the relation of cause and effect. In other instances, however, the cause is persistently present, while the nervous disturbances are of periodic occurrence, for instance, in migraine dependent on astigmatism, and in the few rare cases of epilepsy which have been traced to nasal irritation. Under these circumstances, the examination of the patient can only lead to a tentative diagnosis of the origin of the nervous trouble. The experimental production or exaggeration of reflex neuroses in patients subject to them is possible only in some instances. Thus sneezing fits, spells of nasal cough, more rarely headaches, and occasionally asthma and attacks of syncope may be induced by irritating with a probe the sensitive nasal area of patients suffering from such nasal neuroses, but this experiment is not always successful. Occasionally, too, periodic attacks of the existing neuroses follow intra-nasal cauterization. In various instances of epilepsy due to sensitive cicatrices, the reporters were able to bring on the attacks by pressure upon the scars.

As a rule, however, the reflex origin of a neurosis can only be proven by its cessation after eliminating the cause, a test which constitutes the principle of treatment. If the refraction of the eye is suspected as the cause, absolute rest of the eyes, if necessary, combined with the use of a cycloplegic drug, and finally appropriate glasses, decide the correctness of the diagnosis. If heterophoria, a strain of the ocular muscle during the maintenance of binocular vision, seems to account for the nervous disturbance, the exclusion of one eye by a shade will obviate the immediate consequences of this strain. The nasal neuroses are often checked at the beginning of an attack by the thorough application of cocaine to the sensitive area, although this test is not always positive. And finally, in those instances in which faecal retention or irritation of the bowels by parasites can be suspected as the cause of the neurosis present, systematic intestinal evacuation is the test of the correctness of this view.

In other instances the therapeutic test cannot be as decisive concerning the origin of the neurosis as in those just quoted. Whenever the peripheral lesion is of such a nature that persistent treatment is required for its removal and that some time must elapse before its consequences can be expected to cease, good judgment is necessary to determine whether the neurosis is really of peripheral origin or simply a coincidence. If the interests of the patient demand general hygienic direction besides the elimination of the local disease, the decision is particularly difficult. This explains why our knowledge of intestinal and uterine "reflexes" is so much less positive than the doctrine of ocular and nasal neuroses. Under such conditions, it is only the accumulation of similar well observed cases upon which reliable conclusions can be based.

It might seem as if the most conclusive evidence could be obtained by the surgical removal of the cause of irritation, whenever this is feasible. Indeed, the most brilliant cures of nasal reflexes and of epilepsy due to painful cicatrices come under this head. But here also judgment and neurologic training are required to avoid sources of fallacy. It has been said that some of these cases, for instance asthma of nasal origin, were really cured by counter-irritation, and that the galvano-caustic destruction of the sensory area in the nose acted as a "derivative." This objection could be entertained only if it had been shown that "counter-irritation" anywhere else yielded equally positive results, which has never been done. The validity of the reflex theory has also been assailed on the ground that relapses have occurred after such operative cures. But whenever such relapses were examined by

competent observers (Hack quotes such cases), it was found that they depended on relapses of the local disorders, which the surgical treatment had failed to eradicate thoroughly. Such coincidences are really but an additional proof of the correctness of the "reflex theory."

The real source of fallacy in conclusions based upon the results of operative treatment is, in my judgment, the difficulty of distinguishing between the influence of the operation itself and the influence of the mental impression made by the operation. It is well known to neurologists that emotional impressions and "expectation" may stop for a time, or even dissipate permanently, choreic movements, but more especially hysterical pains and spells, even when they had existed for a long time. It is equally a matter of experience that some cases of epilepsy are temporarily benefited by any new treatment of an impressive nature. For this reason, much familiarity with the clinical history of functional nervous disorders is requisite to enable the observer to decide whether the cure depended rather on mental "suggestion."

The less we know about the pathologic significance of the alleged peripheral cause, the less reliable will be any conclusions as to its relation to co-existing neuroses. Hence skepticism is in place when, for instance, Scheinmann seeks the cause of some nervous condition in sensitive areas wandering from place to place in the nose and reappearing after the operation in another spot. Judgment might also be held in reserve as to the relation of neuroses to low degrees of heterophoria. No doubt there are cases where the strain of eye muscles working under disadvantage leads to nervous disturbances. But to what extent the lower degrees of insufficiencies of ocular muscles—almost normal occurrences—are resented by the nervous system is still an open question. Any oculist who has learned by experience how little the muscular balance of the eye-ball is at times changed by extensive tenotomies in well-marked cases of ocular deviations of the latent type, cannot but doubt whether the mere nicking of muscles in low degrees of heterophoria, cures the patient by influencing the muscular tension or the patient's mind. Indeed the question is a proper one, whether many instances of heterophoria are not by themselves hysterical manifestations, and such a view would be supported by the frequent experience of complete relapses of the ocular deviations after temporary cures by operations on the muscles.

More than mere skepticism, however, is called for, when attempts are made to cure neuroses by muscle-cutting—that is to say, by removing the alleged muscle-strain in the forced effort at binocular vision, in cases which present manifest strabismus and hence have no binocular vision.

When, however, persistent and well-defined nervous symptoms disappear promptly and permanently after the surgical removal of some demonstrable peripheral lesion, or return only if their starting cause relapses on account of insufficient treatment, there can be no logical doubt that the neurosis has been maintained by the peripheral anomaly in question.

In all discussions on "neuroses" it must be clearly kept in view that the manifestations of a disordered nervous system are but symptoms, and that these symptoms may depend on different remote causes in different instances. Similar symptoms may be of "reflex" origin from one organ or another in one case, but may be due to actual lesions in the nervous system in another patient. Hence there is no contra-indication in admitting that epilepsy and chorea are sometimes of peripheral origin, although in most instances they depend on disease of the nerve centres.

The peripheral irritation which can induce nervous disturbances in certain patients is not necessarily and indeed but rarely felt as pain. It may give rise to so little conscious sensation that inattentive patients overlook it, or at least do not connect it with the neurosis started by it. When, for instance, ametropia causes headaches or other neurotic symptoms, the patient may or may not complain of discomfort in the eyes. Personally, however, I have never seen a case in which close questioning did not elicit at least the admission that the eyes did give rise to some slight annoyance when used steadily. Similarly in the case of nasal and pharyngeal disorders. While in some instances the patients may not complain directly, still I was always able to learn by proper questioning that some local disturbance could be felt, though perhaps not enough to suggest it as the cause of the neurosis. But there are also many instances of physiologic reflexes started by an excitation of sensory nerves of which the individual does not become conscious. As illustrations might be mentioned the regulation of the act of accommodation by the blurring of retinal images, the co-ordination of the external muscles of the eye under the influence of diplopia, the self-regulation of the breathing movements by means of the distension of the pulmonary tissue, the changes in the cardiac rhythm and in the size of the arterioles according to local conditions of rest or activity, and many other instances.

A clear insight into the pathogenesis of reflex neuroses can only be obtained by an analysis of all the factors concerned in their production. For evidently the peripheral anomaly starting the neurosis is but one of the factors, or why should a patient with nasal polypi have asthma when so many others suffering from the same

nasal condition escape the secondary affection? Why should but a small number of hypermetropic people get headaches, while the majority of eyes with this deficiency cause only disturbed vision and nothing else? If an irritation alike qualitatively and quantitatively produces disturbances in the nervous system of but one person out of many, there must be special reasons for this exceptional result. Unfortunately our knowledge of the conditions determining neuroses is as yet but very meagre.

The history of patients shows often that the nervous trouble began after some special increment in the intensity of the peripheral irritation. Thus very frequently headaches from eye-strain date back to the time of unusually severe use of the eyes. Again, in other instances, nasal neuroses begin when the chronic nasal condition is intensified by an acute coryza, or when the nose has been irritated by exposure to dust. But these observations, important as they are, do not solve the question why such peripheral irritation will only cause neuroses in some persons and not in others.

In a fair proportion of these sufferers we can recognize hereditary influences. In my inquiries into the family histories in cases of ocular and nasal neuroses, I have very often found similar affections in different members of the family. While it is in no sense an explanation to state that neuroses are more liable to occur in a person predisposed by heredity, still the fact as such is worth noting.

In the sensory neuroses, and especially those of ocular origin, I have learned to regard as important factors the pernicious results of indoor confinement in cities. My case-book contains numerous records of school children and young clerks whose headaches or dizziness or other sensory discomforts were for the time being checked by glasses of moderate strength, but who were equally comfortable without their glasses after a thorough vacation. It is especially during the growing period of life that want of outdoor exercise and close confinement increase the liability to reflex disturbances. Chlorosis also has its share in the etiology of these affections, and where the history shows that the nervous disturbances although clearly of peripheral origin have only begun since anæmia was manifested, iron and hygienic directions are often as serviceable as the correction of the peripheral cause.

The history of some cases shows that the sensory neurosis dates back to the time of recovery from some acute fever—measles, more often in my experience than any other. I have also noticed relatively often that headaches of refractive origin began during the lactation of mothers. In two instances of nasal neuroses, observed by myself, excessive smoking seemed to be a predis-

posing condition, and moderation of this habit relieved the intensity and frequency of the attacks. One of the patients had short attacks of dyspnea with palpitation of the heart, and was ultimately cured by operations restoring the patency of the nose. The other one had periods of cardiac irregularity and acceleration presumably due to papillomata in the nose, but the diagnosis was not made certain, by his refusal to the operation.

A factor to which but little attention has yet been called is the co-existence of several sources of irritation in the system. I. N. MacKenzie (*Am. Jour. Med. Sci.*, April, 1884), has observed that nasal neuroses are often most pronounced during menstruation, and that they can be exaggerated by sexual excesses. It is well known that migraine accompanies the menstruation of some women. In a few instances of migraine especially accentuated during such times, I have proven the ocular origin by successful correction with glasses. Several cases of asthma, the nasal origin of which was shown by the ultimate relief given by nasal surgery, have given me the history of attacks induced particularly during times of intestinal distress, and in these patients dietetic management had a distinct influence on the frequency of the asthmatic attacks. It is common experience, too, that pregnancy predisposes some women to serious nervous symptoms. In some instances of facial neuralgia, of scotoma fugax and of circulatory disturbances in pregnant women, the nasal origin was strongly suggested by the history of the nasal distress, although I have only twice demonstrated the relationship by the success of intra-nasal operations. It should be remembered in this connection, that nasal operations have several times been followed by miscarriages.

It must finally be admitted that in many instances of neuroses of peripheral origin no accessory influences, no disturbances of nutrition, in fact no deviation from perfect health of the nervous system, can be detected. Indeed this seems to be the case in many of the more typical instances in which the elimination of the starting-point stops at once all nervous symptoms. On the other hand, whenever the history shows fluctuations in the intensity of the nervous troubles and periods of intermission, it is more likely that the peripheral cause has been aided in its influence upon the nervous system by accessory baneful circumstances, without which it would not have sufficed to induce the neurosis. These considerations explain also why some neuroses cease spontaneously, in spite of the persistence of the peripheral cause, while others never stop until the starting-point is removed.

Finally it is proper to ask, What is the relation of reflex neurosis to hysteria? While hysterical

persons are not exempt from these troubles, I have neither found in my experience nor in the reports in literature, any large proportion of cases of neuroses of well established peripheral origin in patients with manifest hysteria. I might almost say that where the history of hysteria is clear, the therapeutic test is apt to fail in establishing the peripheral origin of the symptoms. No doubt some of the hysterical complaints, for instance some forms of headache and the globus hystericus are really of peripheral origin. But it seems as if in their production it were not so much the inferior centres, as the cerebral hemispheres, in which the disturbances are induced. For hysterical manifestations when once established are apt so persist, even after the influence which started them has been eliminated.—H. Gradle, M.D., in *Jour. Am. Med. Assoc.*

REPORT ON IRRIGATION OF THE URETHRA AND BLADDER WITHOUT A CATHETER.

Some three years ago my attention was directed to a report of some experiments by H. Felike, of Buda-Pesth, published in the *Internationale Centralblatt für die Physiologie Harn- und Sexual Organe*, which demonstrated that, whereas, under ordinary circumstances, fluids cannot be forced beyond the compressor urethræ muscle, by means of the ordinary urethral syringe, the resistance of this muscle can be readily overcome when subjected to the pressure of a column of water of from one to three meters in height. His method was as follows—

The patient, immediately after a complete emptying of the bladder, was placed in the horizontal position on a table or bed. The blunt nozzle of a fountain-syringe was introduced just within the external urethral orifice, and the meatus gently compressed against it by the thumb and forefinger. The reservoir was then raised to a height of two meters, and the patient instructed to take one or two deep inspirations, allowing the air to rapidly escape by complete muscular relaxation. In a few moments the subject of the experiment would experience a desire to urinate, when it would usually be found that the bladder had been completely filled without the slightest discomfort to the patient, and often without his knowledge.

The idea of irrigating the bladder in this manner, although new to me at that time, was by no means a recent discovery, for upon looking over the literature of the subject, it was found that Dr. C. B. Crossfield had published in the *New London Medical Journal*, in 1792, a report of some similar experiments, in which he succeeded in irrigating the bladder from the meatus by means of continuous pressure furnished by an or-

inary bulb-syringe; and in 1876, Dr. Hunter McGuire reported successful bladder-irrigation in the same manner. Being impressed with the advantages which this method of vesical irrigation offered over the ordinary procedure by means of a double-current or single-current catheter introduced into the bladder, I determined to give it a trial.

The first patient was a middle-aged man who had suffered for twenty-five years from symptoms of chronic prostatitis and posterior urethritis, with the frequent occurrence of an acute bladder-infection, during which he suffered intensely. For these attacks he had frequently been treated by bladder-irrigation, the catheter being introduced in the usual manner. This, while it seemed to have a favorable effect upon the cystitis, was always so painful as to cause acute suffering for a considerable period after the operation, and was often productive of so much irritation in the deep urethra as to render its continued use impracticable. It was during one of these acute attacks that he first came under my observation, and his urgent request for me to avoid, if possible, or at least postpone the introduction of any instrument into the bladder, led to a trial of the method described. The result was strikingly very satisfactory, for the man not only recovered far more rapidly than was usual from such attacks, but he was able to accomplish this result without the dreaded pain which always attended the introduction of a catheter. In this case, after the first two or three washings, the patient was able to irrigate his own bladder without the slightest difficulty, and, on several occasions since this attack, has been able to abort a return of the symptoms by an early resort to this simple procedure.

A number of other experiments were subsequently made with a view of testing the value of this method in patients suffering with various diseases of the urethra and bladder in which irrigation was indicated, and, although the results have not, in every instance, been as satisfactory as in the case cited, it may be said that the irrigations were accomplished with much less discomfort to the patient than is usual when the catheter is employed. The only disadvantages which were observed were in cases exhibiting an unusual amount of tonic of the sphincter muscle, and in these the first few attempts were attended with considerable delay before the fluid would pass into the bladder. In only one case under my observation has it been impossible to accomplish this result.

It is, however, in the treatment of chronic urethritis that this method seems to be most useful. In certain obstinate cases of gleet, especially when there is an involvement of both the anterior and posterior portions of the urethra, the daily

irrigation of the entire canal is often attended with the most satisfactory results. The method most generally employed to accomplish this is perhaps that of Prof. Ultzmann, which consists in the introduction into the deep urethra of a short silver catheter, in the beak of which are several longitudinal slits. This, when in position, is so situated that the longitudinal openings are posterior to the compressor urethræ muscle. Several ounces of a medicated solution are then injected by means of a large, hard-rubber syringe. The fluid, after thoroughly washing the posterior portion of the canal, passes into the bladder, and is later expelled by the voluntary efforts of the patient after the withdrawal of the catheter. This insures a double irrigation of the posterior, and a single washing of the anterior portion of the urethra.

As one of the many methods of treating this most annoying condition, I have often employed the method of Prof. Ultzmann, and frequently with happy results. The objection has been raised by several who have made use of this plan of treatment, that the metallic instrument often produces by its presence in the deep urethra well-marked irritation, giving rise to frequent and painful micturition, with vesical tenesmus. Not infrequently also when spasms of the cut-off muscle is present, the mucous membrane is lacerated by the sharp edges of the longitudinal openings, occasioning considerable hæmorrhage.

Although recognizing the marked advantage which urethral, and especially posterior urethral, irrigation offers over all other methods of treatment in certain cases of this kind, I had practically abandoned its use, owing to the objections stated. As irrigation without a catheter seemed to possess all the advantages of the Ultzmann procedure, and to avoid the chief objections attending its use, a trial of this plan was made in several cases, of which the following is an example:—

B. F., thirty-four years of age, was referred to me by the medical examiner of one of our large insurance companies, to find, and if possible remove the source of a small amount of pus which was habitually present in his urine. There had been a history of several attacks of gonorrhœa during the past twelve years, with a more or less continuous gleet. An examination revealed a penis of three and a-half inches in circumference; urethra free to 34 from bulb to meatus. The urine contained a faint trace of albumin. In the first specimen passed there were found *Trippler-fäden* and a few pus-cells; in the second specimen a small amount of free pus. Endoscopic examination revealed the presence of congested areas and glandular involvement in the bulbous region, with marked hyperæmia of the deeper portion of the canal. The patient had been treated

by internal urethrotomy, sounds, and injections for many months, with some improvement. An irrigation was made by means of the Ultzmann catheter, with as much gentleness and care as possible. Considerable hæmorrhage resulted, and the pain and tenesmus which followed necessitated the patient's going to bed. A day or two later the urethra was irrigated without a catheter, in the manner prescribed, with a 1 : 5000 solution of nitrate of silver, without the slightest discomfort. This was continued daily for a week or more, when the patient was obliged to suspend treatment for a considerable period of time, owing to an enforced absence from home. On his return the irrigations were resumed, with a gradual increase in the strength of the solution, and with marked improvement. It may be added that on two occasions attempts had been made to make applications to the deep urethra through an endoscopic tube, both of which produced extreme irritation. The patient is now nearly well. The pus has disappeared from the second specimen of urine, and only a few *Tripper-fäden* remain in the first.

The foregoing case is reported, not as an example of a cure by this method, for the case is still under treatment, but simply because it illustrates the fact that a sensitive urethra can be irrigated in this manner without irritation.

As to the advantages which this method of urethral and bladder irrigation offers over those usually employed, and which are accomplished by means of the introduction of instruments, it may be said, in general, that there is less danger of septic infection, and far less danger of violence to the parts, and for these reasons it may with greater safety be intrusted to the patient in such cases in which prolonged treatment is necessary.—G. E. Brewer, M.D., in *Med. News*.

THE TREATMENT OF ABORTION.

Something more than a year ago an article by the writer, under the heading of "The Use of the Curette in Abortion," appeared in the *Medical News*, in which a plea was made for the more frequent resort to that instrument in the class of cases under consideration. The present article is designed to further bring out a few of the points to which the majority of the writers and teachers of obstetrics give too little attention. The first of these is the amount of illness which dates from an untreated or poorly treated abortion. The idea which is so prevalent among some members of the profession, that an early abortion is only a slight matter, and needs nothing but rest in bed for a few days, together with the administration of ergot, is to my mind just as dangerous as the idea that a man may marry

while he still has a chronic discharge from his urethra. Either of these conditions contains a latent power for evil which should not be overlooked, and both are regarded as trivial, with what serious results any man may see who chooses to trace the etiology of his cases of metritis, salpingitis, and peritonitis, to say nothing of pyosalpinx and pelvic abscess.

With all due deference to the rôle which the gonococcus plays in the causation of serious disease of the female generative organs, I think it is safe to say that we are in danger of losing sight of the important rôle played by the ordinary germs of decomposition and suppuration in the causation of the same disorders, simply because our attention has been more forcibly called to the serious effects of gonorrhœal infection. Ordinary septic poisoning is the more important in one respect, inasmuch as it is easily preventable in the great majority of cases. That the danger from this source is not exaggerated is shown by the fact that in the course of an ordinary practice and during the past year there have come under my observation six cases in which life was threatened as the result of neglect or careless treatment, to say nothing of the cases of chronic metritis and subinvolution who date their illness from an abortion.

The two most common results of neglected abortion are sepsis—whether acute or chronic—and hæmorrhage. By hæmorrhage is meant not only that which results while nature is attempting to cast off the products of conception, but also that which occurs later, sometimes after the lapse of a month or more, and is the direct result of the retention of portions of placenta, secundines, or decidua. Acute septic poisoning generally shows itself either as a well marked sapræmia from the absorption of decomposing organic material in the uterus, or as an acute inflammation of the uterus, tubes and surrounding peritoneum. Chronic infection is harder to demonstrate, since many patients who are the subjects of chronic metritis have borne children and have lacerated cervixes, and a metritis frequently results from either of these conditions. It does not require a very acute medical vision, however, to see the connection between a foul discharge following an abortion in which the drainage happened to be free enough to prevent systemic infection, and a subsequent subinvolution with leucorrhœa and menstrual disorders. How best to treat these cases and avoid such results is a subject worthy of serious study. In the first place we can expect no brilliant results unless we are cleanly about our work, and to this end antiseptic and not aseptic simply is of the greatest importance. A thorough douching with soap and water followed by a one-half or one-per-cent. creolin solution, or one-to-two-thousand or one-to-

three-thousand bichloride solution, is a necessary preliminary. I know that many cases do well in which all this detail is not carried out, but the acme of perfection, so far as results are concerned, cannot be reached without it. A thorough sterilization of the hands of the physician is another requisite that is too often forgotten because all cases subjected to the danger of infection do not succumb to it. An examination can now be made without danger of rendering the patient worse than she would have been without any attention, and upon the condition which is discovered will depend the further treatment. If the pains are slight, hæmorrhage not severe, and the os not dilated, the use of opium and viburnum prunifolium in full doses with a minute quantity of ergot will often result in a gradual and complete cessation of all dangerous symptoms. The advisability of the use of ergot may be called into question, but I am certain that the combination suggested above has acted better than when the ergot was left out, possibly because the amount used was too small to exert any influence upon the uterine contractions, while it did lower the blood supply to the pelvic organs by its effect upon the arterioles. Of course quiet of both mind and body is requisite if we hope to avoid the threatening danger.

If in spite of a faithful trial of these means or without their being used, the pains are hard, hæmorrhage is threatening, and the os is dilating, the tampon is indicated. Even when the os is fully dilated, if no part of the ovum has passed, it may lead to its expulsion *en masse*, and thus avoid the operation that would otherwise be necessary. This tamponing should be done with cotton wrung from bichloride solution around the cervix, and then completed with baked cotton wrung from sterilized water. These tampons should be removed at the expiration of ten or twelve hours, and replaced again if necessary, but once or twice is all that is desirable. If the os is not dilated or the ovum expelled by this time, it is safe to assume that other means are necessary. I have said nothing about the administration of full doses of ergot to favor the expulsion of the ovum, because I do not believe that it is necessary, and because it is almost as certain to result in the contraction of the circular muscles of the cervix as it is to promote the contraction of the muscles in the body of the uterus. In a case seen recently, two homœopathic physicians were treating a severe hæmorrhage following the expulsion of a fœtus without its envelopes by large doses of ergot, with the result that the patient nearly lost her life before the partly formed placenta could be removed from the cervical canal, where it was caught and held fast by the contractions of the powerful circular muscles.

In all probability the os will have been dilated

by the tamponing if it were not so previous to its adoption, and the ovum may or may not have been expelled *en masse*. The number of cases in which this occurs is very small in comparison to the total number of abortions, but it is so desirable that every means should be employed to favor it.

If this has occurred, and a careful examination of the mass shows us that all parts of the ovum are present, including the decidua vera, further treatment is unnecessary, excepting such as will favor the progress of involution. It cannot be insisted upon too strongly, however, that this mass should not consist solely of the amniotic sac and its contents, but that the decidua vera and rudimentary placenta should both be present if our patient is to be regarded as out of danger.

Supposing, as is frequently the case, that some parts of the uterine contents have passed off when we are first called, and that we are uncertain as to how completely the uterus is emptied; the hæmorrhage may have entirely ceased and the cervix be entirely closed, but that is absolutely no evidence that the uterus is empty. Only too often after one has persuaded himself that the trouble is passed, a fresh and alarming hæmorrhage occurs, or he is confronted by a case of septic intoxication. Actual examination of the expelled material is the only positive evidence of the completion of the abortion, and when this cannot be obtained, or if when obtained it shows that every portion of the ovum has not been expelled, the only scientific and exact method of treatment is the immediate removal of the retained portion. This is also true of those cases of incomplete abortion in which, after the lapse of a few days or weeks from the primary symptoms and supposed recovery of the case, hæmorrhage or a foul discharge ensues. Occasionally we will fail to find anything in the uterus in those instances which might be called cases of secondary hæmorrhage, but the bleeding is due to over-exertion, or subinvolution, or both, yet the operation will none the less surely check the hæmorrhage. An assistant is very helpful, but, as I have remarked elsewhere, is not a necessity. A curetting can be done unaided, if help cannot be procured. Two instruments only are necessary. A speculum, either a bivalve or Sims, yet according to whether one is assisted or not, a pair of dressing forceps, a curette, such as that of Recamier, or, what is perhaps better, one shaped like the Sims' sharp curette, but larger and dull, an intra-uterine douche-tube, and a small pair of placenta forceps. With this armamentarium one can undertake to remove thoroughly all *débris* from the uterine cavity and save his patient the danger of sepsis. With the placenta forceps all large loose particles can be removed, the curette will then loosen the adherent decidua, and this can be picked out with

the forceps and washed with the douche. It may be necessary to go over the surface of the uterus several times before the muscular tissue of its walls is felt underneath the instrument, but inability to feel this firm resistance is proof that some soft foreign material still remains. So soon as the curette and forceps bring away no more material, a final intra-uterine douche should be given, and for this purpose a moderately strong solution of bichloride, such as one to three or one to four thousand, is perfectly safe, as the drainage is free and there is no danger of its retention. This should be used until it comes away perfectly clear, when the operation may be considered at an end, and the antiseptic pad placed over the vulva. If a trained nurse is in attendance, sterilized douches for the first week will promote cleanliness and favor involution; but in the absence of a skilled nurse it would be better to leave the patient alone. A week or ten days in bed is usually as long as is necessary, and if care is used in carrying out the details, perfect recovery is an almost invariable result. Subinvolution is rare after this treatment, and if it should occur is readily and rapidly relieved by the use of galvanism with the positive pole in the uterus.

Rarely packing with gauze is indicated, as when the curetting fails to control hæmorrhage, or inflammation has already occurred in the surrounding structures. In the latter case the serous oozing which it causes is of enough benefit to offset its disadvantages. As a routine practice I believe it does more harm than good by preventing the expulsion of any possible clots or small shreds which might have been loosened and left behind during the operation and it is impossible for me to see any indication for its use excepting in the cases above mentioned. This procedure has its uses, but at the present time it is subject to many evident abuses which are bound in time to react and totally obscure its usefulness.

The three following cases are cited as illustrations of the serious results likely to follow careless or improper treatment:

CASE I.—Mrs. J. P., aged thirty-two, multipara. On June 5, six weeks from last menstruation, was taken with a slight hæmorrhage and some pain which continued for two weeks, but which she persistently refused to believe was due to an abortion. These symptoms gradually ceased, and were succeeded by a slightly foul discharge. The patient was informed of the necessity for removal of the uterine contents, but would have nothing done. July 10, without any warning a hæmorrhage occurred of such severity that she lost consciousness within fifteen minutes. The uterus was curetted ~~at~~ once, with immediate cessation of the bleeding, but she has never recovered completely from the effects of the terrific hæmorrhage, and still continues pale and weak.

CASE II.—Mrs. A. B., aged twenty-three, multipara. On January 15, after missing one period, the patient had pains and hæmorrhage with passage of clots and pieces of ovum. She remained in bed for two or three days, when the symptoms all subsided, and she gradually resumed her household duties. Two weeks later she complained of feeling chilly at times, and a foul discharge from the vagina made its appearance. In a few days more she was compelled to go to bed, and when she was first seen her temperature was 105.5° F., pulse very rapid and weak, and she showed every evidence of acute septic intoxication.

The uterus was curetted the same day, and a large amount of decomposing *débris* removed. The next morning the temperature was 99° F., and it never rose above normal again.

CASE III.—Mrs. J. L. C., aged twenty-five, multipara. This patient has had two or three abortions previous to this one, and never suffered any inconvenience from them. On this occasion, after missing one period, she began to flow and pass pieces which she described as looking like flesh. When consulted on July 20 I advised that a curetting was necessary, but this was declined, and she persisted in being up and about. The bleeding was followed by a foul lochial discharge, but she did not consider it necessary to again consult a physician until two weeks later, when a severe pain in the left ovarian region manifested itself. Examination revealed an induration over the entire pelvic floor on the left side. Cleansing the uterus produced only temporary relief, and the patient passed through a three weeks' siege with pelvic peritonitis, with finally an abscess formation on the left side. This was opened and drained through the vagina. She rapidly recovered her general health, but three months later an accumulation of pus took place in the left tube for which abdominal section, with removal or drainage as found advisable, was recommended, but so far has not been accepted.—R. E. Skeel, M.D. in *Inter. Med. Journal*.

CLINICAL REMARKS ON AFFECTIONS OF THE RIGHT SIDE OF THE HEART.

That affections of the left cavities of the heart should seem to outweigh in importance those of the right side is the natural consequence of the fact that disease on the right side is seldom primary, and that its distinctive signs are commonly overshadowed by those of the conditions with which it is associated. It should, however, be remembered that in most cases of valvular heart disease compensation is chiefly effected by means of an increased activity of the right ventricle, that

it is the failure of the latter that precipitates the onset of the common symptoms of backward pressure in the veins, and that so long as the right ventricle can propel the blood the patient may continue to enjoy immunity from urgent symptoms, in spite of extensive valvular disease on the left side. The circulation in such a patient, as I once heard an eminent physiologist observe, in some degree resembles the circulation in the fish. In the fish the blood is driven by the one ventricle through the gills, where it is aerated, and the *vis a tergo* suffices to drive it onwards into the aorta, and so throughout the systemic vessels. In like manner, when there is great destruction of the mitral valve in man, the onward movement of the blood in the aorta must be largely dependent on the *vis a tergo* on the other side of the lungs; and, in a certain degree, proportionate to the damage to the valve, the left ventricle becomes a mere channel for the blood to flow through. Such being the case, it is scarcely necessary to insist on the importance of attending to the condition of the right ventricle in the study of cases of valvular heart disease.

By far the most frequent form of valvular disorder on the right side of the heart is tricuspid regurgitation, and as a diseased condition we meet with it almost daily associated with mitral disease—stenosis or incompetence—or with impeded circulation in the lungs from emphysema and bronchitis. The well-known safety-valve action of the heart is a provision by which, when the right ventricle is over-distended, the chordæ tendinæ pull upon certain parts of the tricuspid valve in such a way that it no longer closes during systole, and a certain amount of regurgitation takes place until the ventricle has got rid of the excess of blood it contained. When dilatation more or less permanent has arisen from excessive internal pressure, the same mechanism comes into play. We then see the familiar symptoms of impeded circulation in the veins, and we may often distinguish a systolic murmur in the tricuspid area. When a mitral murmur is present it may not be easy to decide whether a tricuspid murmur also exists, but the latter may often be differentiated by its having a point of maximum intensity near the sternum. In cases of dropsy depending on lung disease this murmur is often distinct, and in favorable cases may be observed to diminish in intensity, and even disappear as the patient recovers.

But although increase of pressure in the pulmonary artery usually takes effect on the tricuspid valve, in some cases its action is manifested elsewhere. The well-known effect of high tension in the systemic arteries upon the aortic valves would lead us to look for similar effects on the pulmonary valves when tension is raised in the arteries of the lungs. Probably pulmonary regurgitation

from this cause would be more frequent than it is were it not for the safety-valve action of the right ventricle, and its occasional occurrence was pointed out by Dr. Fothergill. I have little doubt that it was present in the following case:

CASE I.—*Mitral Regurgitation; Obstructive and Regurgitant Murmurs in Pulmonary Area.*—M. M., aged 36, housewife, admitted into the Royal Infirmary under my care in the absence of Dr. Davidson, May 15th, 1893, with dropsy in legs and abdomen. Her illness began eight months before with palpitation and dyspnoea on exertion, followed by swelling in the legs. She denied having ever had rheumatism. When first admitted there was great abdominal distension, which was relieved by successive tappings, and the pulse was quick; but the general condition improved greatly in two or three weeks, and I was able to note carefully and repeatedly the exact conditions of the heart. The pulse was regular in time and force and of moderate rapidity, and was not in the least suggestive of aortic disease. The impulse was in the sixth left intercostal space, $5\frac{1}{2}$ inches from the middle line and $1\frac{1}{2}$ outside the mammillary line. It was regular and strong and no thrill was felt. The second sound was reduplicated, and was loudly accentuated at the pulmonary cartilage. In the mitral area there was a loud systolic murmur, conducted towards the left axilla, and heard at the back. There was also a loud systolic murmur heard at the right border of the sternum at the base of the ensiform cartilage, apparently due to tricuspid regurgitation. In the pulmonary region two murmurs were heard, the one systolic, the other diastolic. The systolic murmur was loud, had the rough quality of a direct murmur, and was conducted towards the left clavicle; the diastolic murmur was soft; it began with, or directly after, the second sound, was heard best in the second left intercostal space close to the sternum, and was also audible in the third space and faintly in the first. In the aortic area a much fainter systolic murmur was heard, probably radiated from the left side; but no diastolic murmur was present, nor was one heard at the lower end of the sternum nor in the carotid artery.

Primary endocarditis is as rare on the right side of the heart as it is common on the left, judging from the extreme infrequency with which signs of inflammation, either old or recent, are found in *post-mortem* examinations in this situation. I once found some vegetations, probably recent, about the size of a split pea, on the margin of the tricuspid valve, when I was making a *post-mortem* examination on the body of a patient who died in the Stanley Hospital some years ago; but I have, unfortunately, not been able to find the notes of the case among the records at the hospital. The following case, treated in the Royal Infirmary,

seems to have been one of rheumatic endocarditis affecting the tricuspid valve :

CASE II.—*Antecedent Rheumatism; Loud Systolic Murmur in Tricuspid Area.*—W. J. R., aged 17, errand boy, admitted under my care, in the absence of Dr. Davidson, June 15th, 1893, suffering from some functional nervous disorder, apparently independent of the condition I am about to describe. He stated that he suffered from shortness of breath and swelling of the legs, and that when 11 years old he was treated in the Children's Infirmary for rheumatism and heart disease. While he was under my care a systolic murmur was audible all over the precordium, and was very loud in the tricuspid area. Its point of maximum intensity was at the left border of the sternum at the level of the fourth intercostal space, and it could be heard to the right of the sternum. In passing from the tricuspid to the mitral area it diminished in intensity, and although it was loud in the former situation it was quite inaudible at the back.

In the foregoing instances the murmurs pointed with tolerable clearness to organic disease on the right side of the heart ; but it need hardly be said that murmurs in the pulmonary region generally admit of a different interpretation. Not to speak of hæmic murmurs, which are always systolic, and are hardly likely to be misinterpreted, we sometimes hear a diastolic murmur in this situation, while yet the associated conditions make us hesitate to affirm that pulmonary regurgitation is present. In the following case the interpretation of such a murmur presented no small difficulty :

CASE III. *Mitral Stenosis and Regurgitation; Diastolic Murmur in Pulmonary Area probably Aortic in Origin.*—F. J., aged 16, confectioner, was admitted under Dr. Caton on June 3rd, 1893. She had had rheumatic fever two years, and a second attack seven months, before admission. The heart was enlarged, its action tumultuous, pulse 96 ; there was a presystolic thrill at the apex, and a diastolic shock at the second left cartilage. At the apex we heard a long, rough presystolic and a systolic murmur, which together occupied nearly the whole cardiac cycle. In the second left interspace a *bruit* was heard with the second sound, having the peculiarity that it lessened in intensity, or even disappeared, at the end of expiration. There was no systolic murmur in the same region, but one was heard at the aortic cartilage. The tumultuous action and the presence of loud mitral murmurs throughout nearly the whole cardiac cycle made the exact differentiation of the diastolic murmur very difficult, but the absence of a pulmonary systolic murmur made it unlikely that there was regurgitation, since, according to Dr. Balfour, in all cases of pulmonary regurgitation the murmur has been double. Further, the pulse was somewhat collapsing, and

there was visible capillary pulse ; the conclusion arrived at was that there was aortic regurgitation, and that the murmur was really aortic in origin. The indications of the sphygmograph are not often of practical value, but the tracing in this case had a percussion stroke of great amplitude, and so far supported the diagnosis of aortic disease. It is not easy to say why the murmur was not heard in the usual situation.—T. R. Bradshaw, M.D., in *Brit. Med. Jour.*

THE TREATMENT OF LITHÆMIA.

After what I have told you, how this disease is produced by over-eating and over-drinking and lack of exercise, how the oxygenation of these urine products is prevented, how there is more coming in than going out, the treatment plainly presents itself before you. Stop the amount of nitrogenous material ingested ; insist upon out-door life and exercise ; get the skin function fully to work ; this will do a great deal at once. You can cure lithæmic headache in this way, by diet and exercise. What is the best diet for a person forming uric acid and allowing it to remain in the system ? My answer is, a vegetable diet, green vegetables, especially spinach, celery, egg-plant, onions, and cabbage—any diet of that kind, with the single exception of asparagus. If a man could become chiefly a vegetarian he would not be troubled with lithæmia. Carbohydrates are not good ; starches must be used in moderation. Bread is to be largely forbidden ; fatty matters must be taken sparingly, and it is the verdict of lithæmics that sugars do the greatest amount of harm. In addition to this, patients must be restricted in the use of animal foods, unless it be such things as the white meat of chicken and birds, which are not rich in nitrogenous material. Do I forbid meat to my lithæmics entirely ? That depends upon the case. If I have a patient who will follow my instructions about exercise, who will indulge in athletics sensibly, and will keep on exercising, he may eat meat in moderation as long as he works it off. If I have a sedentary person to treat, I greatly restrict the diet. Oysters and fresh fish are allowable. Whatever articles of food produce acid fermentation in the body must be avoided by the lithæmic.

What should the patient drink ? Water, and plenty of it. Above all, he should avoid alcohol. Patients will tell you that they are accustomed to a certain amount of alcohol, without which they cannot work. If you are obliged to allow alcohol I would recommend it in two forms : whisky considerably diluted, and a good brand of claret. German wines are bad, and champagne is worse on account of the sugar it contains and the acid reaction which it produces. Many persons will

tell you that champagne causes pains in the joints and in the tendo Achillis.

In regard to the matter of taking stimulants, patients will deceive you. I had a case of lithæmia recently which I tried in vain to do something for. I was strict about diet and the usual directions as to medical treatment. At each visit to my office I would ask him if he was temperate and what he took at meals. For breakfast he stated he took coffee without much sugar, fish, very little bread, mostly stale, and water. When I came to lunch, he said it was plain, but upon his hesitating, I asked him if he took anything to digest his food. He said, "Yes, always a quart of claret!" At dinner he took nothing but fish and green vegetables, and it occurred to me to ask him another question, whether he carried out my instructions about drinking water before going to bed, to dilute the acid in the urine. He said he took something to make him sleep, and that "something" was three whiskeys! You see how careful you must be about the statements of patients. If you get them to take water, and nothing else, you will do a great deal for their cure.

Now, gentlemen, a few remarks on the strictly medical treatment.

Among the many articles which have been used I will select those only that I know to be valuable. In the first place, I am an earnest advocate of mild laxatives, especially salines, such as Hunyadi water, Saratoga water, phosphate of sodium. I would recommend their use two or three times a week. This makes the liver act better and enables it to get rid of the broken-down waste material. Among other remedies, I have found continued courses of carbonate of lithium very useful. I often give a capsule of two grains of this with a sixth of the extract of nux vomica, and keep patients on it for a long time with great benefit. When the nervous system is much affected you will also obtain at times good results from small doses of arsenic, but always with the laxatives. Whether there are any remedies which directly act on uric acid is a question. Salicylic acid in the form of sodium salicylate is strongly recommended. I do not approve of this as a remedy for any length of time, as it disorders digestion. A similar agent, salol, I have seen give good results. In regard to the new article, piperazine, I like it so far as I have used it; but I do not think it is the solvent of uric acid it is supposed to be. In outbreaks of migraine of lithæmic character, you must relieve pain and get rid as rapidly as possible of the uric acid in the system. You cannot wait for the slow treatment of diuretics; you cannot wait for exercise; something must be given for immediate relief, such as small hypodermics of morphine, for large ones will interfere with excretion, and thus accumulate acid in the system. At the same time active purgatives are to be em-

ployed. An eminent physician, who has been himself a great sufferer, recommends for prompt effect dissolving the uric acid in the system with acids. It would be risky to repeat this treatment often. To prevent a recurrence of the attacks, diet is all-important.—Prof. Da Costa, in *Coll. and Clin. Rec.*

THE TREATMENT OF OPEN FRACTURES.

If aseptic surgery had been practiced only in the treatment of open (compound) fractures, it would have accomplished much for humanity. It is safe to say that there are not one half as many amputations performed since the commencement of the present treatment as formerly. Lives have been saved that otherwise would have been sacrificed, and useful limbs are now seen where a few years ago, a wooden substitute was worn as a perpetual reminder of the shortcomings of the surgical art. The aseptic treatment of an open fracture requires first the thorough cleansing of the limb and the wound. The limb should be shaved and washed clean. Irrigation with boiled water is the best means of securing cleanliness of the wound. If there should be venous oozing, it should be stanching with hot water, or irrigated with a bichlorid of mercury solution 1 to 4,000. The styptic effect of this solution is at once seen in the bleaching and drying effect produced. Any spurring vessel should be tied with carefully sterilized catgut. The next step is to secure accurate coaptation of the fragments, sharp splinters (spiculæ) should be removed, but broad fragments, even when considerably comminuted, should be re-adjusted. The elevator and the heavy bone forceps will be frequently needed to bring the fragments into position. It is well-known that the principal causes of non-union, outside of constitutional causes, are: 1, want of apposition; 2, interposition of muscles; 3, excessive motion. Every care should be taken therefore to avoid these causes of non-union.

Direct fixation of the fragments is one of the most important indications. This may be accomplished by periosteal suture or bony suture. I have many times secured good union in bones of the foot, for example, by the periosteal suturing of the fragments. Chromicized catgut or whale tendon should be used, and a sufficient number of stitches taken to bring the fragments together. In case the obliquity is such the fragments can not be brought together by periosteal suturing, then the osseous suture may be made; after trying many experiments, and experimenting with many kinds of suture, I have reverted to silver wire as being that best adapted to the work. These sutures in some soft bones may be passed obliquely through with a stout needle, but gener-

ally a small drill hole must be made to enable the passing of the wire. The wires must after twisting, be left long and project from the wound so as to facilitate easy removal.

I have had no experience with the use of bone dowel plug placed in the medullary canal to secure fixation. It has seemed to me so liable to be septic, and there must be so many practical difficulties in the way of final removal, as to make it a dangerous appliance.

In five cases I have used the bone ring introduced to the notice of the profession by Professor Senn. In every case there was suppuration, and I have abandoned it, until such time as we shall be enabled to sterilize the ring. It is yet so far from perfection in that regard, as to make it almost certain that the wound will become infected. The principle may be yet found useful by the invention of some different material. The bone ring (or thimble) has one advantage, that is the great amount of exudate (forming. So pronounced is this effect, that in cases of ununited fracture where there is no attempt at the formation of callus, the ring may be used to advantage notwithstanding its general lack of sterilization.

The condition of the soft parts must next be looked to. Indeed it is a matter which is scarcely secondary to the proper treatment of the fractured bone. Wounded tendons, torn muscular structures and lacerated nerves should be sutured according to the rules laid down for respective tissue involved. Stout chromicized catgut will be found useful for tendons, and fine flexible catgut for nerves. In case the distal and proximal ends of a nerve or tendon can not be brought together, they may be sewed to the nearest adjoining nerve or tendon. All this takes time, but it will be well spent. When the wound is cleaned the bones are brought together, and the soft structures thus attended to, then irrigation is again practiced and the external wound closed by sutures of silk worm gut. Extension is usually not necessary if the fragments have been brought into perfect apposition, nor is there much difficulty in retaining them. External support should be secured by a plaster-of-paris bandage, and when necessary a fenester cut opposite the wound.

In complying with the wishes of our distinguished chairman, to keep within the ten minute line, it will be seen that I have chosen rather to support the existing practice, than to compile the literature of the subject, and if more attention shall be directed to methods of suture of the soft parts, in addition to bone fixation, the paper will have served its purpose.—Jno. B. Hamilton, M D., LL.D., in *The Journal*.

PRESCRIPTIONS.

FOR WHOOPING-COUGH.

R—Sulphonal gr. j.
Creasoti, ℥ij.
Syrupi Tolutani.
Aque, āā ʒij.
Misce et fiat mistura.

Two teaspoonfuls to be given every two hours.

FOR AMENORRHŒA.

R—Hydrargyri Perchloridi, . . . gr. ʒ.
Sodii Arseniatii, gr. j.
Ferri Sulphatis Exsiccatae, . . . gr. xxx.
Potassi Carbonatis, gr. xv.
Extracti Nucis Vomicae, . . . gr. v.
Misce et divide in pilulas xxx.

One pill to be taken before each meal.

FOR BRONCHORRŒA.

R—Copaibæ, ʒij.
Tincturæ Chloroformi Compositæ, ℥xx.
Mucilaginis Acaciae, ʒvij.
Liquoris Potassæ, ʒj.
Aque Cinnamomi ad, ʒviiij.
Misce et fiat mistura.

An eighth part to be taken three times daily.

FOR BRONCHITIC ASTHMA.

R—Extracti Stramonii, gr. ʒ.
Potassi Iodidii, gr. v.
Ammonii Carbonatis, gr. iv.
Tincturæ Lobeliae Ætheræ . . . ℥v.
Aque Chloroformi ad, ʒss.
Misce et fiat mistura.

A tablespoonful every four or six hours.

PASTE FOR ECZEMA.

R—Acidi Salicylici, ʒj.
Zinci Oxidi, ʒiiij.
Pulveris Amyli ʒiv.
Adipis Lanæ Hydrosi, ʒj.
Misce. Fiat unguentum.

To be applied daily.

—Practitioner.

A NEW METHOD OF ADMINISTERING CREOSOTE.
—(*New York Medical Record*, March 10, 1894.)
By Dr. R. W. Wilcox.

The writer states his belief that in creosote we have a very valuable remedy for pulmonary tuberculosis, but it requires to be administered in large doses, two to three drachms a day, which may give rise to untoward, even poisonous, symptoms. In his experience guaiacol, even in doses proportionate to its percentage in creosote, is by

no means equally efficient. Hitherto he has been most successful in the administration of creosote in the form of enteric pills, but even with these, gastric irritations, backache, and malaise occasionally occur. Very lately he has used the carbonate of creosote, that is beechwood creosote (ninety-two per cent.), in chemical combination with carbonic acid (eight per cent.). It is a clear, pale, almost colorless liquid of syrupy consistence, becoming thinner by heat. It is insoluble in water, but soluble in alcohol, or in four to five parts of cod-liver or olive oil. It has a slight odor of creosote, and an oily, slightly tarry taste, which is in marked contrast to the burning taste of creosote. It can be administered clear or by hypodermic injection. Dr. Wilcox prefers its administration in either hard or soft gelatin capsules containing ten or twenty minims each. In large doses it may give a dark green color to the urine, an indication to diminish the dose, but this is apparently the only untoward symptom. There is no malaise, nor irritation of the stomach or intestines. Dr. Wilcox thinks that fifteen to twenty drops per day is probably a sufficient dose for children, but adults may take one, two or even four drachms per day in divided doses.—*Inter. Med. Mag.*

DIPHTHERIA TREATED BY ANTITOXIN.—The following case, with its highly satisfactory result, seems worthy of record, for, although a single instance of any treatment can have but little scientific value, and it might, therefore, have seemed wiser to wait until one could publish a series of cases, I have thought that by recording this, the first case of antitoxin treatment of diphtheria at Guy's Hospital, others might be encouraged to make further experiments speedily. We may thus the sooner ascertain how far we have in antitoxin an effectual therapeutic agent against diphtheria. I am indebted to Dr. Goodhart for kind permission to publish the case, which was under his care:

J. C., aged three years, was admitted at 2 p.m. on June 23rd. It was said that he had been at play, and apparently quite well that morning. At midday he complained of his throat, and had croupy cough, and respiration soon became difficult. On admission there was considerable inspiratory stridor, and some "sucking in" above and below the clavicles, and also in the lower intercostal spaces. On the right tonsil was a patch of membrane. The tonsils and fauces were very slightly injected and swollen. The temperature was 102.4°, the pulse 140, and the respiration 34. The color was good, but the child was distressed and restless. Tracheotomy seemed imminent, but the operation was deferred till bed and steam kettle had been tried. At 4.30 p.m., antitoxin Mxj was injected hypodermically in the forearm,

with strict antiseptic precautions. At 6 p.m. the patient seemed more comfortable. The temperature was 92.2°; respiration continued difficult, but the patient was less restless and slept fairly well during the night.

June 24th. The temperature was about 99° all day, the pulse 128, and the respiration 32. The child was again becoming restless, and stridor was increasing. Antitoxin Mviiij was injected at 4.30 p.m.

June 25. The stridor was much less. The child was playing and talking and took solid food; the temperature was normal.

From this time the stridor decreased. The child seemed perfectly well, playing and laughing merrily, although the cough remained croupy until June 27, and membrane persisted on the tonsil until June 30th, that is, seven days.

The diagnosis was made certain by cultivation from the membrane.

The only additional treatment adopted was a steam kettle and tent bed, and brandy Mxxx every four hours. A spray of iodine and carbolic acid was tried twice on June 23rd, but as the child objected it was not used again. The antitoxin used (kindly given by Messrs. Zimmermann & Co.) was Schering's. Whether the favorable result was *post hoc* or *propter hoc*, it is noteworthy that the subsidence of constitutional disturbance was extremely rapid, occurring within a few hours after the injections; that the constitutional improvement occurring while the visible membrane persisted, apparently without corresponding improvement; and last, but not least, that the injection would seem to be entirely innocuous, being followed by neither local nor general disturbance.—*British American Journal.*

ABSCESS IN THE RIGHT CEREBELLAR HEMISPHERE, ASSOCIATED WITH PARALYSIS AND FITS LIMITED TO THE SAME SIDE.—The surprise and disappointment experienced by my colleague, Dr. Hume, and myself in connection with the following case will be readily understood after perusal of the brief record I venture to submit to the readers of the *Lancet*. It is, I think, at all times expedient to give publicity to our failures, but it is an imperative duty we owe to the profession to make known our misfortunes when an exception, real, or apparent, to a well established principle happens to underlie them. The disappointment was intensified by the fact that the attempt to interpret the clinical symptoms aright was made with great care.

The patient, a girl nine years of age, was sent into the Royal Infirmary by a medical man who furnished the statement that for some years there had been a purulent discharge from the right ear, and that a few days prior to her admission headache, vomiting, paralysis of the right arm, and

right-sided convulsions developed. The child was well grown, but thin. She lay in bed on the left side. The right arm was helplessly paralysed, the right angle of the mouth was weak, and the leg on the same side showed evidence of paralysis, though certain voluntary power remained. Every hour, and sometimes more frequently, the fit returned. The spasm began in the face and almost immediately extended to the arm and occasionally to the leg, but remained limited to the right side. During the interval between the fits the child seemed to regain consciousness, and without doubt she did so when the interval was unusually lengthened, and then it was observed that she was completely aphemic—that is to say that she seemed completely unable to utter a syllable, though to a certain extent she understood spoken language. There was early optic neuritis. No obvious discharge was to be detected from either ear, though cotton wool introduced into the right meatus was soon moistened with offensive purulent fluid. The side affected with spasm and paralysis (the right) of course suggested a lesion in the left temporo-sphenoidal lobe, and a careful examination was made for evidence of left middle ear mischief, and was found in the shape of a perforation and some foetid discharge. It was therefore decided to explore the temporo-sphenoidal lobe on the left side in search of an abscess. This my surgical confrere Dr. Hume, did in the usual way, but without success. He next trephined over the left arm-centre, but we were again disappointed. Finally he explored the left lobe of the cerebellum, but with a like result. During the few days succeeding the operation the patient seemed to be somewhat better, at all events the fits were less numerous and consciousness was regained, but the arm remained paralysed and the speech defect was unaltered. She died a week later, and at the post-mortem examination a large abscess cavity, holding about an ounce of pus was found, in the right lobe of the cerebellum, located near the surface and about three quarters of an inch from the medulla. The left cerebral hemisphere presented no pathological changes other than the usual subarachnoid hæmorrhage consequent upon the exploratory punctures. Both tympanic cavities were extensively diseased. I may say that I made the post-mortem examination myself and searched carefully for a lesion on the brain that would explain the right-sided paralysis and convulsions, but found none. It will thus be seen that any attempt to explain the symptoms by direct pressure upon the motor tract below the decussation is highly unsatisfactory; but apart from the remote situation of the abscess, pressure on the medulla would scarcely cause localized convulsive seizures, nor would it paralyse the facial muscles. We are, indeed, forced to conclude that the explanation lies in one of two directions:

either a lesion in the left hemisphere has been overlooked, or the paralysis and fits, limited to the right side, were the result of some indirect influence (reflex) arising through the known connection between the right cerebellar lobe and the motor cortex of the left cerebral hemisphere. The case is to me a great puzzle, especially as I am convinced the former hypothesis is incorrect.—*Lancet*.

“KLEPTOMANIA.”—The close connection between moral error and mental disease is a circumstance which constantly imposes upon the practitioner a difficulty of the same duplex character in relation to diagnosis. Moral alienation, it is well known, indicates from a very early stage the decay of the reasoning faculty. Moral insanity, in like manner, denotes that mental state which exhibits in its feeble and absolute submission to the senses the failure of healthy self-control. Among its innumerable forms, an interest which is not entirely pathological attaches to the sometimes rather comical vice of “kleptomania.” The question of criminal responsibility overshadowed by this term brings it more or less within the scope of public opinion. There are, no doubt, a number of cases which illustrate only what may be styled the disease. They are manifestly related to other like extravagances of manner and action, and are the obvious effects of insane suggestion. The thefts of the imbecile and the general paralytic belong to this class; others, however, show some connection with method and motive. These, especially if unrelated to other signs of insanity, must be regarded with suspicion. There is, for example, a practical difference between the act of a person otherwise sane enough, who impulsively pockets your household silver, and that of another, who vainly labors as in a case actually recorded, to stow the coal-scuttle in his nether garments. In deciding the question of responsibility, therefore, the evidence of motive and the presence of other and grosser morbid symptoms, especially the latter, should, in our opinion, be allowed to exercise a most important influence.—*The Lancet*.

In the report of an inquest held last week respecting the sudden death of a servant, the cause of death was defined in the following words:—“Owing to decay part of the heart had become detached, and, travelling up the main artery, it had reached the head, where it completely blocked the cerebral arteries. No medical skill could have saved her life!” Clearly as all the heart could not take a holiday at once, this was apparently an instance in which it endeavored to do so in detachments. But even then the results were disastrous.—*Medical Press*.

Reports of Societies.

REPORT OF THE CANADIAN MEDICAL ASSOCIATION.

The twenty-seventh annual meeting of the Canadian Medical Association was held in St. John, N. B., August 22nd and 23rd. Dr. T. T. S. Harrison, of Selkirk, Ontario, presided, Dr. F. N. G. Starr, of Toronto, acting as secretary.

After opening, Dr. Jonah, of Eastport, was introduced to the Association as representative of the Maine Medical Association; and Dr. Bulkley, delegate from the American Medical Association. Dr. Charles O'Reilly, I. H. Cameron, and J. E. Graham, delegates of the Ontario Medical Association, were also present and accorded a hearty reception.

A large number of new members were proposed, principally from the Maritime Provinces.

Letters of regret were read from Sir Charles Tupper, Dr. Osler, Dr. Marcy, Dr. Bray, Dr. Mullin, and Dr. McLean, of Detroit.

Dr. Hattie, of Halifax, read a paper on "Epilepsy," which consisted of the explanation of the possible cause of the trouble. This was the result of certain experiments and observations he had made on epileptics. He reported what had been discovered after post-mortems made on epileptics, but these changes in the cells were probably the result of the nerve storm, rather than a cause of it. The more probable cause lay in the action of some toxic irritant which was the result of some systemic disease. He pointed out that anæmia was present in epileptics, and said that it might be the condition upon which the disturbance depended. On the supposition that the poison might be absorbed from the intestinal tract, he had administered intestinal antiseptics with the bromide; he compared the number of fits during a given time with this treatment, with the number occurring when the bromide alone was given, and when nothing was given at all. The new treatment showed a marked decrease in the number of convulsions.

After the discussion of his paper by Drs. Cameron, of Toronto, and Wright, of Ottawa, Dr. Muir, of Truro, N. S., reported the history of a case of local tuberculosis of the arm which had been cured after the accidental inoculation of erysipelas. The patient was a female, aged 39, who had been suffering from the disease for 14 years; the arm between the elbow and the wrist being

very much swollen, brawny, riddled with sinuses, which were discharging most offensive pus. Under chloroform these sinuses were scraped out and antiseptic and deoderant dressing applied. There was little improvement in the condition until after the wound became infected with the erysipelatous germ. The result was that the arm completely recovered. The paper was discussed by Dr. Daniels, Dr. Shepherd, Dr. Bulkley, Dr. Cameron, and Sir James Grant; Dr. Muir closing the discussion.

Dr. Harrison delivered his presidential address, taking as his subject his observations and experience in medicine during the past fifty years. He compared the diseases in existence then with those we have now. Since the clearing up of the country in the Province of Ontario, the miasmatic diseases had become things of the past. He referred to the horrible concoctions of domestic medicine, such as an infusion of sheep excrement for measles, and that of a cat, which he said might not be considered a bad substitute for *asafoetida*, was the "sovereignest" thing in fits. The old veteran referred to many practical points in his practice. He pointed out the danger a man was in of becoming egotistical, or of getting into a rut, when he was so far removed from other medical men. The corrective of this he considered to be the attendance of medical associations. A considerable portion of the address was taken up in discussion of the question of inter-provincial registration. Every practitioner in Canada, he considered, should have the right of practising in any part of the Dominion, without having to submit to an examination. He believed in a high standard, both as to matriculation and graduation.

The President was accorded a hearty vote of thanks, moved by Dr. Bayard, of St. John, seconded by Dr. Hingston, of Montreal. Dr. Wright, of Ottawa, moved, seconded by Dr. I. H. Cameron, of Toronto, that a committee be appointed, representing the various provinces, to consider the suggestions made in the President's address with regard to the question of inter-provincial reciprocity.

Dr. James Bell, of Montreal, read a paper on "Appendicitis." It was a review of his work in the Montreal General Hospital during the past eleven months, in connection with the surgical treatment of this disease. He had had 48 cases; 40 were operated upon; 8 were not; all recovered except 3. He advocated that appendicitis should receive treatment at the hands of the surgeon from the beginning of the attack. In the great majority of cases he believed, as soon as the diagnosis was completely established, operation should be resorted to. The interesting reports of his cases seem to bear out his view in this respect.

Dr. Hingston, of Montreal, took the conserva-

tive side of the question. He had prevented the operation about thirty times, and only regretted that he did not operate in one case. He did not want the younger members of the association to go away with the idea that operation was the thing in every case they had. Dr. Bell was a distinguished surgeon, first; and, second, the cases he saw were the worst types.

Sir James Grant reported two cases of appendicitis, one the gouty form, the other rheumatic. He found it difficult to decide when to operate, and he knew of no more perplexing point in surgery. It required great observation, discrimination and judgment to know how to deal with them. He did not believe the trouble was due to concretions found in the organ. He attributed the causation to the insufficient time taken to masticate food, and allied causes common to the rush of to-day.

Dr. Shepherd pointed out that the surgeons get the worst cases, so it was difficult to say just what the proportion of cases was which were operated on. Some one had spoken of unloading the cæcum at the beginning of the attack; he had never found or heard of anything being found in it at the *post-mortem* table. He advocated operating in the interval as the safest time. In regard to McBurney's point, he thought the tenderness was due, not to the appendix, but to the inflamed condition of the mesenteric glands.

Dr. Strange believed in non-interference till there was evidence of pus; and then to open the abscess, as one would any other abscess. He leaned to the conservative treatment from his experience with the disease.

Dr. Cameron was in favor of the conservative line of treatment. In the majority of his cases he had not operated at first, and had found his results to be as good as those in which the operation was performed in every case early. He thought it unfortunate that the experience of a hospital surgeon of skill should determine the matter one way or the other. With regard to the gangrenous form due to embolism of the appendiceal artery, one should operate. He agreed with Dr. Shepherd that the interval was the time to operate. The difference was, Dr. Shepherd operated before pus formed and closed the cavity; while he (the speaker) did not operate till pus formed, and he did not close the cavity.

In replying to the discussion on his paper, Dr. Bell made a strong plea in favor of his statement—"one should always operate." It was generally agreed that no one knew when to operate, and if the patient were left, at any moment perforation might take place. However, in the forty cases he had operated on 30 were perforated and abscess was present at the time of operation; in three the appendix was wholly gangrenous, and here, he said, one could not wait for the tumor forma-

tion or the abscess. In two the appendix was bound down; in three it was not perforated, but gave rise to urgent symptoms, yet there was no abscess found. He used to follow the waiting treatment, but found it unsatisfactory. The mortality was much greater than that of his eleven months of the new plan. The greatest mortality statistics for the operation only amounted to from two to three per cent. The operation as a rule was not difficult. He considered the plan of waiting for pus not the best surgery. The very mild cases, where the symptoms passed off in, say 12 hours, he would not interfere with; they were probably only cases of caecitis.

"Eye-strain Headaches," was the subject of a paper read by Dr. Morrison, of St. John, N.B. He gave an extensive list of such cases where the true cause had not been found, and as a consequence the varied forms of treatment gave satisfactory results, only in so far as they gave rest, unconsciously, to the eyes, and supported the general bodily health. A school boy had Wednesday headaches, resting Saturday and Sunday from study, the eyes stood the strain till Wednesday, when he was obliged to lie off. Suitable glasses directed to the correction of the astigmatism and hypermetropia effected a cure. Often the patient was treated for a long time for some other disorder altogether. The eye should, in the headache cases, be taken into consideration; for, he affirmed, 90 per cent. of all cases were due to eye-strain. Treatment must be directed to a correction of the mechanical defects in the cornea; to strengthen the delicate muscle of accommodation, by tonics and massage; for young ladies he recommended gymnastic exercises.

Dr. Laphorn Smith, of Montreal, followed by a paper on "The Treatment of Diseases of the Ovaries and Fallopian Tubes." The subjects of gonorrhœal and tubercular salpingitis, tumors of the ovaries, ovarian congestion and neuralgia, were elaborately referred to, their most prominent symptoms pointed out, and also their treatments. The paper was practical, inasmuch as numerous histories of cases were recited, and pathological specimens shown.

Thursday, a.m.

The Nominating Committee brought in the following report:—President, Dr. Bayard; General Secretary, F. N. G. Starr, M.B., Toronto; Treasurer, Dr. Small, Ottawa; Vice-Presidents, Drs. Shaw, of Hamilton, Ont.; Armstrong, Montreal, Que.; McLaren, New Brunswick; McKeon, Nova Scotia; Blanchard, Man.; Haultain, N. W. T.; Maclaren, P. E. I.; Edwards, B. C. Provincial Secretaries for the above Provinces named in order: Fenwick, of Kingston; Campbell, of Montreal; McNally; Hattie; N. S. Nelson, Man.; Macdonald, N. W. T.; McNeil, P. E. I.; Richardson, B. C.

"The Influence of the Mind on the Body," was the subject of the address on medicine, delivered by Dr. Bayard, of St. John, N. B. In a concise way the Doctor gave a *résumé* of the general anatomical and physiological features connected with the nervous system, and pointed out that various mental phenomena were causative of marked change in the body, particularly in respect to the action on the vaso-motor nerves. He had known pain to disappear in the presence of sudden danger; and he quoted Hunter as saying, "My life is at the mercy of any scoundrel who chooses to put me in a passion;" and, strange to say, that was the cause of his death. It was believed that the elaboration of the blood constituents was interfered with when the individual was under emotional excitement. He then proceeded to discuss the various nervous troubles so common to-day, and suggested means for their prevention.

"The Use and Abuse of the Various Cautery Agents in the Treatment of Nasal Affections," was treated by E. A. Kirkpatrick, of Halifax. He referred first to the delicacy and importance of the nasal mucous membrane, and said that too often it was the subject of harsh treatment. Caustics were used, perhaps, more in hypertrophic rhinitis than in anything else, and often too severely. Of the caustics he said chromic acid, trichlor acetic acid and the electro cautery were the principal. The chromic acid he used in anterior applications, the cautery for the posterior applications. By the injudicious use of caustics he had seen the mucous membrane destroyed. And in some cases he had seen very serious sequelæ follow in connection with the ear; such as loss of hearing, and mastoid disease.

Dr. J. E. Graham presented a paper on "Some Forms of Functional Derangements of the Liver." The paper dwelt on the great importance of maintaining the integrity of the hepatic cells. They acted as a guard against the invasions of certain forms of poisons into the general circulation—such as arsenic and phosphorus among the mineral kingdom; the poison of decaying meats and old cheese, in the organic; absorption of poisons generated in a distended stomach; the specific toxins of typhoid and such diseases; and the absorption of poisons from the intestinal tract as when constipation was present. These various poisons tended to injure the cells, and passing into the general circulation produced their effect on the nervous and other systems of the body. In the ordinary cases of biliousness the symptoms were pointed out as depending on functional disturbance of the liver cells, and consequent absorption of ptomaines, etc. The glycogen and urea producing functions of the liver were also discussed, and the results of their abeyance pointed out through the damage done to the hepatic cells. As to treatment, Dr. Graham urged the absolute necessity of

finding the exact cause of the disturbance, before rational treatment could be employed. He recommended restriction and regulation of the diet; suitable exercise to assist the circulation; proper attention to bathing, drinking of mineral water to promote metabolism, where the urea was deficient; the necessity of free purgation; and, lastly, the various specific remedies recommended for this condition.

Dr. Hingston, of Montreal, reported four cases of brain operations, two of which were for epilepsy. A third was for the relief of a young man who had received a skull injury some twenty years before, which had resulted in paralysis of certain muscles of the arm, and spasm of certain of the muscles of the face. Operation afforded almost complete relief. The Doctor showed the kind of trephine he used, being one two inches in diameter. He pointed out its advantages over the smaller ones.

Dr. F. J. Shepherd, of Montreal, reported a case of "inter-scapulo thoracic amputation," the first, he believed, that had been performed in Canada. It was in a stout woman, for a chondro-sarcoma surrounding the shoulder joint, which was causing serious pressure symptoms and inability to use the arm. The Doctor described the technique of the operation. The principal point of difficulty was in reaching the subclavian artery. He left the scapula intact.

He also reported the removal of a large enchondroma of the pelvis, which appeared as a continuous growth with the ilium. He (the patient) had been refused operation in New York and Philadelphia. Upon dissection it was found to be sub-gluteal, and only having two attachments. Its removal was comparatively easy. The reader of the paper presented photographs of the cases. He also reported the removal of a cirroid aneurism, which gave him a great deal of trouble in checking the bleeding.

Dr. Buller, of Montreal, read a paper on "The Present Status of Asthenopia."

Dr. Inches, of St. John, N. B., read a paper on "The Prevention of Tuberculosis." He pointed out the danger of infection from diseased animals in their meat and milk, stating that in herds of cattle sometimes as high as 98 per cent. of the animals were affected. Then there was the great danger from the sputum of the tuberculous patient. Of course, suitable soil was necessary for the growth of the bacillus. He stated that in the perfectly healthy individual it could not propagate, or was not likely to; but in very many the general health was lowered either by hereditary predisposition or through unsanitary surroundings. For its prevention, the first thing to be attended to, was the injunction of perfect cleanliness as regards the sputa, on the part of the infected patient. The second was the establishment of special hos-

pitals for this class of sufferers. Those patients who belonged to the wealthy classes might be treated otherwise, but for the great majority of the cases separate hospitals were exceedingly desirable. In Italy their establishment had lessened the mortality very greatly.

"Some Practical Points in the Treatment of Diseases of the Skin," was the subject of a paper by Dr. Bulkley, of N. Y. He emphasized the necessity of the most careful examination and note-taking in these cases, at every visit of the patient, and the necessity also of persistent treatment. In eczema, he said to be careful about the use of new remedies. He was much opposed to the indiscriminate use of arsenic. He recommended the use of the alkalides to combat the acid state of the blood found in eczema. Acetate of potash was what he used. Externally the custom was to use two irritating ointments. One of his favorite prescriptions was—

R.—Ac. carbol, one-half drachm.
Calamine preparata, one drachm.
Zinci ox., two drachms.
Glycerin., three drachms.
Aq. calcis, four drachms.
Aq. rosæ, four ounces.

But he had found that the correction of some fault in diet or habit of the patient, and the administration of hygienic and tonic treatment of the greater importance. He also went into the subject of acne and other common troubles, and mentioned some very valuable points.

Dr. Laphthorn Smith gave a very interesting exhibition of the use of the galvano-cautery, in which the street lighting current is used. He showed how simple, and far superior it is to the old battery arrangement. The cost was trifling.

Dr. MacDonald, of Hopewell, N. S., addressed the Association on the "Prevention of Tuberculosis," in which he drew attention to the fact, that of 67,688 deaths in the Dominion, 7,490 were from consumption. His object was to direct attention to means for its prevention. This consisted in the destruction of the bacillus-laden tissue or sputa. He referred to what had been done in the way of prevention in Pennsylvania, Nova Scotia and other places. He was anxious that the profession should urge upon the State the necessity of progressive action in the way of notification, registration and the establishment of sanitarium, both for the sake of the patient and the safety of his friends.

Dr. Hamilton, of Montreal, read a paper on "Adhesions of the Soft Palate and their Treatment."

"A Medico-Legal Romance" was the subject of an interesting paper by Dr. Steves, of St. John Lunatic Hospital.

Dr. Fenwick then presented a paper on "Hysteropexy."

After the customary votes of thanks the meeting closed. The next meeting of the Association will be held in Kingston, Ontario.

A THERMOMETER REMOVED FROM A MALE BLADDER.—The *Medical Press* describes the following unique case:—It is well known that foreign bodies of curious types may be sometimes found in the female bladder, for the female urethra, owing to its structure, does not much interfere with the wilful insertion of hair-pins and other such substances. The case, however, is very different when the male urethra is concerned. Experience teaches that it is not common for the surgeon to be called upon to remove a foreign body which has been intentionally introduced into the male bladder. However, a curious instance of the kind has just been recorded by Le Dentu. A young Breton, aged 26, was admitted under his care into the hospital with a history of having suffered for ten years from bladder symptoms. Micturition was frequent and painful, and the urine contained blood and a large quantity of pus. Exploration of the bladder with a sound revealed the presence of a calculus, the precise size and relations of which it was impossible to ascertain, owing to the extreme irritability of the bladder. A supra-pubic cystotomy was performed, and when the bladder was opened a long and thin almost immovable calculus was found. An endeavor was made to extract the calculus entire, but this was unsuccessful; accordingly a pair of strong forceps was introduced into the bladder and the foreign substance was broken in half; the fragments were then easily removed. Subsequent examination showed, as had been suspected during the course of the operation, that the calculus had formed around some foreign body, and further investigation revealed that the latter was a thermometer, the length of which was ten centimetres. The patient made a good recovery. The interesting feature of the case, about which, however, the author says nothing, is the circumstances under which the thermometer came to be inserted into the bladder. It is curious, too, that for ten years the patient had never come under the care of a surgeon who had detected the presence of the foreign body.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science, Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Address, DR. J. L. DAVISON, 12 Charles St., Toronto.

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AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAH' LER, 23 Rue Richer, Paris.

TORONTO, SEPTEMBER, 1894.

The LANCET has the Largest Circulation of any Medical Journal in Canada.

ANIMAL EXTRACTS.

It is to be regretted that the introduction of animal extracts has been attended with so much quackery. Doubtless marked and beneficial results have been obtained from the administration of Thyroid Extract in some cases of myxœdema.

It must be remembered, however, that the thyroid is a secreting gland, which has been shown experimentally to have a direct effect in the production of this disease, and one can easily understand, that, if through a deficiency in quantity or quality of its secretion, a pathological condition arises, the administration of an extract of the gland, by supplying the deficit, might bring about a return to the normal condition of affairs. This may warrant its use in diseases evidently arising from affections of the thyroid gland, but its employment in lupus, internal tuberculosis, cancer, etc., as we have seen it recommended, is, in the light of our present knowledge of pathology and bacteriology, most unscientific, and can only have the effect of bringing the remedy into disrepute. The action of nervine, cerebrine, cardine and numerous other "ines" are not supported by such scientific evidence, and it is to these we refer in speaking of quackery. As well might one attempt to restore an amputated leg by the use of *Cruvine*, *Genuine*, and *Pedine*, as expect cerebine to form a new corpus striatum, in place of one that has been ploughed up by the blood from a ruptured middle cerebral artery. A very unpleasant and disgrace-

ful feature of this subject, is the way in which these extracts are being advertised, not only in medical journals, but in the public press.

The pendulum of medical thought is seldom at rest, and as with almost every new remedy, so will it probably be with thyroid extract; received with open arms as a panacea for almost all ills; rejected as quickly and fervently as accepted, when found unqualified for the position to which it was assigned; and eventually, after serving a long apprenticeship, become installed again in general confidence, but with very much limited functions.

THE MICROSCOPE IN MEDICINE.

Microscopy is not only an interesting study, but is rapidly becoming, in fact has become, a very necessary part of the modern physician's means of diagnosis and consequent guide to treatment. While a few years ago much valuable time was lost waiting for physical signs to develop, in order to settle the diagnosis, in the present day, with our staining reagents and microscopes, we are able to demonstrate the existence of tubercular disease, in many cases, long before the pleximeter and stethoscope afford anything but negative signs.

The results of treatment in the later stages of phthisis have not materially altered from those of former years, but in those cases recognized before any extensive damage to lung tissue or interference with the general health has taken place, large numbers of recoveries have been reported, and much unnecessary expense and suffering avoided. If only for the sake of these cases, which exist in such large numbers, every practitioner should be possessed of a microscope and understand the preparation and examination of sections.

But these are not the only cases in which a microscope is of value. Diseases of the blood may be readily recognized, the differential diagnoses accurately made, and the effect of treatment carefully watched.

In diseases of the genito-urinary organs, and frequently in affections of the skin, the microscope is indispensable to both the physician and surgeon. It should be impressed upon the student at the beginning of his course, that a microscope is absolutely necessary for the proper pursuit of his studies, both before and after graduation. Auscul-

tation may be done by the immediate method, but one cannot do microscopical work with the naked eye. The management of the microscope is quickly and easily learnt, the staining and preparation of sections being merely a matter of technique. The expense is insignificant when compared with the immense advantages to be derived from its use.

MEETING OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNÆCOLOGISTS.

The American Association of Obstetricians and Gynæcologists will hold its seventh annual meeting, in the Council chambers of the College of Physicians and Surgeons, at Toronto, Ont., on Wednesday, Thursday and Friday, September 19th, 20th and 21st, 1894.

The following is the preliminary programme :

1. President's address, George H. Rohé, Catonsville, Md.
2. Personal Experience with Pus Tubes: When to Operate, How to Operate, and the Results of Operation, James F. W. Ross, Toronto, Ont.
3. Relation of Hysteria to Structural Changes in the Uterus and Adnexa, A. P. Clarke, Cambridge, Mass.
4. Demonstration of a Mechanism of Intussusception (rabbits), Robert T. Morris, New York.
5. Nephrectomy, L. H. Dunning, Indianapolis.
6. Treatment of Distension of the Fallopian Tubes without Laparotomy and Removal, Frank A. Glasgow, St. Louis, Mo.
7. Hysteria in Pregnancy, W. P. Manton, Detroit, Mich.
8. Relations of Renal Insufficiency to Operations, Carlton C. Frederick, Buffalo.
9. (a) Importance of Recognizing Septic Puerperal Endometritis early, and its Treatment; (b) Demonstration of a Portable Operating Table for Gynæcological and Abdominal (Trendelenberg) Work, Edward J. Ill, Newark, N. J.
10. Suspension of Retroflexed Uterus by the Utero-ovarian Ligaments, with Report of Cases, Reuben Peterson, Grand Rapids, Mich.
11. The Element of Habit in Gynæcic Disease, Geo. F. Hulbert, St. Louis, Mo.
12. Some Results of Ether Anæsthesia in Abdominal Operations, I. S. Stone, Washington, D. C.
13. Report in Abdominal Surgery, Presenting Cases, A. Vander Veer, Albany.
14. Supplementary Paper on Abdominal Sec-

tion in Intrapelvic Hæmorrhage, M. Rosenwasser, Cleveland, O.

15. Conservative Midwifery, J. M. Duff, Pittsburg, Pa.
16. The cause of the Thirst following Abdominal Section, Eugene Boise, Grand Rapids, Mich.
17. The Care of Pregnant Women, W. B. De-wees; Salina, Kansas.
18. The Present Status of the Surgical Treatment of Uterine Fibroids, Lewis S. McMurtry, Louisville, Ky.
19. *Discussion.*—Inflammatory Disease of the Uterus and Appendages, and of the Pelvic Peritoneum; (a) Introductory Remarks, Wm. Warren Potter Buffalo; (b) Historical Sketch, Edward J. Ill, Newark, N. J.; (c) Clinical History, Chas. A. L. Reed, Cincinnati, O.; (d) Causation and Pathology, Lewis S. McMurtry, Louisville, Ky.; (e) Diagnosis and Prognosis, James F. W. Ross, Toronto, Can.; (f) Treatment, M. Rosenwasser, Cleveland, O.; A. Vender Veer, Albany, N. Y.; J. H. Carstens, Detroit, Mich.; A. H. Cordier, Kansas City, Mo.; (g) Results—(a) When Untreated; (b) Under Various Methods of Treatment, Joseph Price, Philadelphia, Pa.
20. Intercurrent Typhoid Fever in Pregnancy, Thomas E. McArdle, Washington, D. C.
21. Notes on a Case of Cholelithiasis, Frederick Blume, Alleghany, Pa.
22. Perineal Operations, Joseph Price, Philadelphia, Pa.
23. Remarks Bearing on the Surgical Treatment of Intussusception in Infants, based on Two Successful cases, Henry Howitt, Guelph, Ont.
24. The Limitations of Surgery in the Treatment of the Uterus and its Appendages, William H. Myers, Fort Wayne, Ind.
25. The Incision in Abdominal Surgery—Methods and Results, J. H. Carstens, Detroit, Mich.
26. Abdominal Section in Ectopic Gestation, where the Fœtus is Living and Viable, X. O. Werder, Pittsburg, Pa.
27. Restoration of Intestinal Continuity without Mechanical Devices, Wm. E. B. Davis, Birmingham, Ala.
28. Hysterectomy for Cancer of the Uterus, E. W. Cushing, Boston, Mass.
29. Chronic Progressive Atrophy of the Vulva (Kraurosis Vulvæ), its Pathology and Radical Treatment, Charles A. L. Reed, Cincinnati, O.
30. The Reason why Patients Recover from Tuberculosis of the Peritoneum after Operation, Robert T. Morris, New York.
31. Report of two cases of Injury of the Ureter following Operation for Cancer of the Uterus, L. H. Laidley, St. Louis, Mo.

32. Vrginal Fixation of the Uterus as a cure for Retro-displacements, Clinton Cushing, San Francisco, Cal.

33. Hydrosalpinx, A. H. Cordier, Kansas City, Mo.

34. *Discussion*—Should Antiseptic Vaginal Douching be made a Routine Practice in the Puerperium? Referees, A. H. Wright, Toronto; Thos. Lothrop, Buffalo; J. Edwin Michael, Baltimore, Md.; A. T. Machell, Toronto.

35. Infectious Diseases during Pregnancy, Dr. A. H. Wright, Toronto.

36. Congenial Diaphragmatic Hernia—Reports of two Cases, H. T. Machell, Toronto.

37. Reports of some Interesting Abdominal Operations, with exhibition of specimens, Rufus B. Hall, Cincinnati, O.

The annual dinner of the association will be held in the Toronto Athletic Club, on Thursday, September 20th, 1894, at 7 p.m. Members of the medical profession desiring to attend the dinner may procure tickets from the committee of arrangements during the forenoon of the first day of the meeting. Covers will be laid for the number signifying their intention to be present up to this time, and the list will then be closed.

AMERICAN PUBLIC HEALTH ASSOCIATION.—

The twenty-second annual meeting of the American Public Health Association, will be held at Montreal on September 25th to 28th. The Association was organized in 1872 for the purpose of inaugurating measures for the restriction and prevention of contagious and infectious diseases, and for the diffusion of sanitary knowledge among the people. The growth of the Association and the work it has accomplished more than justify its existence. Its membership has been augmented from year to year until it now constitutes the largest and strongest sanitary body in the world, and embraces in territorial extent the United States, the Dominion of Canada and the Republic of Mexico.

The Local Committee of Arrangements is at work to insure a large and profitable meeting. Railways have reduced their rates to one fare and one third, provided certificates of attendance be produced when leaving Montreal on the return trip. Special blanks will be furnished on demand by ticket agents at all stations, said agents having to give a receipt for the going fare received.

Officers for 1893-'94.—President, Dr. E. P. Lachapelle, Montreal, P. Q.; *1st Vice-President*, Dr. M. Carmona y Valle, Mexico, Mex.; *2nd Vice-President*, Dr. J. N. McCormack, Bowling Green, Ky.; *Secretary*, Dr. Irving A. Watson, Concord, N.H.; *Treasurer*, Dr. Henry D. Holton, Brattleboro', Vt.

Officers of Local Committee of Arrangements for the Montreal Meeting.—Dr. Robert Craik, *Chairman*, Montreal; Dr. Elzear Pelletier, *Secretary*, 76 St. Gabriel Street, Montreal.

For application blanks or further information, apply to the Local Committee of Arrangements.

EARLY SYMPTOMS OF MENTAL DISEASE.—*The British Medical Journal* contains the following translation from the *Berl. Klin. Woch.*, May 28th, 1894, in which Wemer draws attention to the importance of early diagnosis from the point of view of treatment. In early melancholia, sleeplessness is marked, though the patient still continues to follow his occupation. A feeling of sadness and depression, with distaste for work, then supervenes. He may appear indolent, and weeps on the least occasion. Sometimes there is unreasoning irritability, followed by depression. The appetite is impaired, and the patient may thus think himself the subject of some hopeless disease. He has præcordial anxiety and then develops diseased ideas, perhaps with hallucinations. The early stage of mania is often one of depression. Sleeplessness, irritability, dislike of work, self-accusation may also be present here. It is very characteristic of mania when the patient suddenly passes into the opposite extreme, the pleasure in life, etc., re-awakening. One may make all kinds of purchases, another write verses, etc. If contradicted he may become incensed or even violent. Acute paranoia develops very rapidly, and is characterized by hallucinations (hallucinatory form), numerous delusions, self-over-estimation, mistrust, unrest, etc. In the chronic form, the symptoms may date from some time back, even from childhood. The child holds itself aloof, is sensitive, obstinate, etc. With years the peculiarities increase, ideas of persecution may occur, and large ideas, with or without hallucinations. To this group belongs the paranoia querulenta often appearing after the loss of a lawsuit. In paralytic dementia the initial symptoms are very varied.

Bodily symptoms mostly prevail, such as pains in the limbs, head pressure, slight difficulty in speech, etc. There is sleeplessness, loss of appetite, constipation. Years may pass, the patient improving a little. Later the mental symptoms become more marked. The patient is abnormally irritable or indifferent. He may become extravagant. The impaired intelligence is obvious. Unequal pupils, speech troubles, facial palsy supervene. For oncoming melancholia or mania, removal to a suitable institution is best, and also for acute paranoia. The percentage of recoveries may thus be increased. Drugs should be given only under constant supervision. For chronic paranoia change of scene, hydrotherapy, etc., should be recommended, and removal to an institution only when the patient is unmanageable, or the home conditions unsatisfactory. An early general paralytic is treated in the same way, but the strictest supervision is required.

PIPERAZINE AS A URIC ACID SOLVENT.—Confirmatory evidence (*Med. Summary*) of the utility of piperazine as a solvent for uric acid in the body has recently been afforded by the experiments of Dr. Rosenthal on animals, *Medicine Post*. These experiments consisted in producing deposits of uric acid in the heart, pericardium in the bladder and kidneys, and then administering piperazine in doses of 0.75 gramme by the mouth or subcutaneously. After a period varying from two to seven days, the animals were killed, and in all of those which had been treated with the remedy a complete disappearance of the uratic deposits was observed. On the other hand, the control animals which had been treated with borax, phosphate of sodium and lithia, exhibited considerable collections of uric acid in the different organs. On the ground of these experiments, Rosenthal regards piperazine as the most reliable solvent for uric acid. Albuminuria was never observed. Dr. Blanc, *American Journal of the Medical Sciences*, April, 1874, also states that "theoretically the use of piperazine is very encouraging. An alkaloid of the pyridine group, it is not poisonous nor irritant. The combination of urate of soda and this drug is nearly nine times more soluble than the urate of lithia. Vogt has found that under fifteen grain daily doses the amount of urates is decreased, while that of urea increases.

This goes to show that not only does this drug dissolve urates, but it is an oxidizing agent and modifies tissue change. On the other hand, the nitrogen which is eliminated is not increased, which shows that there is no increase of waste nor supplementary decomposition of albuminoids. Piperazine has been strongly recommended for gout, in that it relieves the pain, frees the engorged joints, and expels renal calculi. Patients who have suffered from nephritic colic, some days after the drug experience a recrudescence of the pain, which is followed by the expulsion of a large calculus which has apparently been diminished in size by the action of the drug. In this respect it appears to act with less danger than do the alkalies, and more rapidly than the flushing out of the kidneys with mineral waters." Piperazine-Bayer is a chemically pure preparation, and is furnished in half-ounce and ounce vials, and also in tubes of ten tablets, each tablet containing sixteen grains, which is an average daily dose.

DEATH FROM HÆMORRHAGE AFTER TOOTH EXTRACTION.—Dr. Elliott Bates, (*Annals of Surgery*) reports an interesting case showing the profound respect with which the surgeon should regard all cases of hæmophilia. The patient was a man aged twenty-five years, who had been delicate from childhood, suffering at intervals from painful joints and digestive troubles. On one occasion in childhood a slight accident resulted in profuse hæmorrhage, and twice he nearly lost his life on account of hæmorrhage after extraction of a tooth. He determined, however, to risk it a third time. Gas was administered and the tooth removed. Hæmorrhage followed, but diminished steadily after the cavity had been packed. It returned, however, during the night, and in the morning the patient was in a state of collapse from loss of blood, the face and lips being pale and cold, while he also had tinnitus aurium and dimmed vision. In spite of treatment by hypodermic injections of whisky, strychnia, and saline solution, the patient continued to lose blood and gradually became weaker, finally succumbing seventy-six hours after the extraction of the tooth. There was no trace of any similar condition to be discovered among the patient's relations. On the maternal side there was a phthisical taint, and on the father's a neurotic tendency.

THE INFLUENCE OF ALCOHOL, GLYCERINE AND OLIVE OIL ON THE ACTION OF DISINFECTANTS.—Lenti summarizes in the *British Medical Journal* the results of a series of researches as follows: (1) Alcohol in the absence of water neutralizes all bactericidal power on the part of sublimate or phenol with regard to anthrax spores, and the bactericidal action is not exercised until the dilution of the alcohol with water becomes greater than two per cent. in the case of 1 in 1000 sublimate solution, or than seventy per cent. in the case of carbolic acid. The length of time to which the spores were subjected to the action of the solutions was twenty-four hours in the case of sublimate, and forty-eight hours in that of phenol. (2) Glycerine has a similar impending action, interfering with the action even of a 2 in 1000 solution of sublimate, if the proportion of water be less than forty per cent. In the case of phenol it is still more manifest. (3) Phenol and lysol dissolved in olive oil have no disinfectant action when tested as above. (4) In the preparation of a disinfecting fluid one ought, therefore, to avoid the addition either of alcohol, glycerine or fats.

AN EPIDEMIC OF PRIAPISM.—The *Boston Medical and Surgical Journal* reports the following unique epidemic: Dr. Meynier, a French army surgeon, has recently published a curious bit of medical experience. A company of troops *en route* having halted for some time at El Hacaiba, the men were nearly all seized with priapism and prolonged and painful erections. Considering that an absence for some time from a garrison town might be the cause, the surgeon ordered light diet and flax-seed tea. The condition, however, became steadily worse. The erections continued throughout the company, and the men began to complain of great lassitude and dryness in the throat. Finally many had marked hæmaturia. Careful investigation disclosed the real cause of the trouble. During their leisure the men had been hunting frogs at a neighboring stream. The poplar and willow trees along the banks were found to be thickly covered with coleoptera of the family of cantharides, *meloe*. Chilled in the early morning, they fell by thousands into the water, where they were gladly and greedily devoured by the frogs—which latter gave similar

pleasure to the soldiers. The taste of the flesh was in no way injured, but its effect upon the genito-urinary system of the divers was disastrous. The removal of frogs' legs from the bill of fare put an end to the curious epidemic in a few days.

A SUIT FOR MALPRACTICE IN CINCINNATI.—Dr. C. D. Palmer, of Cincinnati (*Phys. and Surgs.*), has just had a suit for malpractice decided in his favor. In 1888, while performing a perineal operation upon a woman, he broke the needle, and careful search failed to find one of the fragments, either in the tissues or elsewhere. The patient not acting satisfactorily under the anæsthetic, further search was considered unwise, and the operation was concluded. Soon afterward the doctor received injuries in a runaway accident, remaining unconscious, or semi-unconscious, for about a month, and being utterly unable to attend to practice for a year. In the meantime another physician operated on the woman, and found the needle encysted. Suit was brought for \$10,000. The jury rendered a verdict for the defendant on the first ballot. Dr. Palmer has been Professor of Gynecology in the Medical College of Ohio for a quarter of a century, and is connected with the Cincinnati and Presbyterian Hospitals.

AN ANTIDOTE TO STRYCHNINE.—M. G. Grigorescu (*Archives de Physiologie, 1894, No. 1, p. 32*), in the course of some experiments to determine the action of toxic substances upon the excitability of peripheral nerves and muscles, developed the fact that butyl-chloral opposes the toxic action of strychnine. He found that if injections of strychnine were made (in frogs), those which received also the butyl-chloral remained torpid, while those with strychnine alone were tetanized; the least noise increased the tetanus of the latter, but the former did not show any spasm. After some hours the butyl-chloral was eliminated, and then these frogs were seized with tetanus, as were the others. On repeating the antidote up to the elimination of the strychnine, complete cures resulted. On experimenting with larger frogs similar results were obtained. The observations demonstrate that butyl-chloral energetically opposes its physiological action to the physiological action of strychnine.

AN IMPERIAL BRITISH PHARMACOPŒIA.—It is

proposed to revise the British Pharmacopœia and with a view to better adapt it to Colonial requirements, medical, chemical, botanical and pharmaceutical friends are invited to send to John Attfield F. R. S., 17 Bloomsbury Square, London, W. C., Eng., any reports of original observations and researches bearing on the pharmacopœia.

It is to be hoped that the glaring inconsistencies in which it abounds will be remedied.

It has been pointed out by Mr. Attfield that great saving might accrue by the use of indigenous substances in the Colonies in the place of the more expensive foreign article, such as, the use of an indigenous oil for olive oil in the preparation of ointments, plasters, liniments, etc.

A MEDICAL MAN FINED FOR CONTEMPT OF COURT.—The inquest on the body of a man named Cooper (*Medical Press*), a shoemaker, who was shot by a man named Winters, who afterwards committed suicide, in Goldsmith's-row, Hackney-road, was considerably delayed by the action of Dr. O'Regan, who declined to hand over the revolver with which the crime was committed. The inquiry had to be adjourned, and Dr. Regan then produced the weapon. He asked for his fee as a medical witness, but instead was fined £1 by Mr. A. Hodgkinson, the deputy-coroner, for his conduct in the matter. The doctor said that he should appeal against the coroner's decision, and has done so, with the result that he has been informed by the Treasury Commissioners that they decline to remit the fine.

AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.—The fourth annual meeting of the American Electro-Therapeutic Association will be held in New York, September 25th, 26th and 27th, at the New York Academy of Medicine. Members of the medical profession are cordially invited to attend.

WILLIAM J. HERDMAN, M.D.,
President.

MARGARET A. CLEAVES, M.D.,
Secretary.

COUGHING-TAXIS.—In the *Lancet*, January 27th, Dr. Wherry, University Lecturer on Surgery, Cambridge, declares that he has frequently found that coughing on the part of the patient during taxis was a great aid in reduction of hernia. He

cites one instance in which after two physicians, aided by chloroform, had failed to reduce, he succeeded by gentle taxis continued for fifteen minutes while the patient coughed continuously. It was a femoral hernia, severely strangulated, in a middle-aged woman.

ECZEMA OF THE VULVA.—Lusch recommends the following treatment:

R—Sod. bicarb.,	8.0
Potass. bicarb.,	4.0
Glycerin. pur.,	6.0
Tr. opii.,	8.0
Aq. destill.,	250.0

Sig.—Wash the affected parts night and morning with the above and then powder with:

R—Amyli.,	98.0
Camph. trit.,	2.0

A NEW METHOD OF PRODUCING THE IODINE REACTION IN AMYLOID TISSUE.—Galeotti (*Lo Sperim. ; B. M. J.*) describes a new method of demonstrating the extent of amyloid degeneration. It consists in soaking the sections in a solution of potassium iodide, then rapidly washing them in distilled water, and immersing them in chlorine water. The amyloid tissue alone retains the iodine salt, so that when this latter is attacked by the chlorine water, it is the altered part alone which is stained by the liberated iodine. The test is said to be extremely delicate.

MAGISTRACY, MEDICINE AND MALINGERING.—The special usefulness (*Boston Med. and Surg. Jour.*) of a medical magistrate is reported from England. A workhouse inmate was arraigned before a medical J.P., charged with refusing to work, to which he pleaded that he was a victim of heart disease, whereupon the magistrate promptly descended from the bench, produced a stethoscope, auscultated the culprit, and re-ascending the throne of justice, sent him "up" for seven days for malingering.

A SUCCESSFUL SPLENECTOMY.—Dr. James Murphy, of Sunderland, England, did a splenectomy upon a woman forty-five years old, on April 25th. The operation was undertaken for abscess and hypertrophy. The wound healed promptly, and at last reports the patient was making a satisfactory progress.

SULFONAL.—It should be borne in mind (*Maryland Med. Jour.*) that to obtain a prompt, safe and agreeable effect from sulfonal it should always be given in hot solution cautiously cooled to a drinkable temperature, so as to avoid precipitation. By adopting this plan, not only is a smaller quantity of the drug required, but sleep occurs much more rapidly and is not followed by after-effects.

ELEGANT GLYCERIN JELLY.—The following directions are given in the *Pharmaceutische Zeitung*: Soak two drachms of gelatin in six fluid ounces of rose water, and then liquefy by applying heat. To the somewhat cooled liquid, before solidifying, add five drachms of albumen, again apply heat to coagulate the albumen. In the perfectly clear liquid dissolve 12 grains of salicylic acid, add 5 fluid ounces of glycerin, and strain or filter on a hot-water funnel. Pour into wide-mouthed bottles and allow to solidify.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The *Lancet* states that at the meeting of the Council of the Royal College of Surgeons of England, held recently, Mr. J. Whitaker Hulke, F.R.S., was re-elected President of the College. Mr. Reginald Harrison, and Mr. Alfred Willett were appointed Vice-Presidents.

MARRIED.—On Wednesday, June 27th, 1894, at the residence of the bride's parents, Harwich, Ont., by the Rev. J. Becket, of Thamesville, Dr. P. B. Robertson (Trinity, '91), of Newbury, Ont., to Maggie, only daughter of Alex. Clark, Esq.

A STATUE of the late Dr. J. Marion Sims is shortly to be erected in Byrant Park, New York. The statue is from the chisel of the well-known French sculptor, M. Dubois.

THE use of the metric system of weights and measures has now been made compulsory in the prescription and dispensing of medicines in Russia.

DR. G. S. MOORE, of Glasgow, recently deceased, bequeathed \$225,000 to found a convalescent home for nurses.

THE wet nurses in Austria are on a strike.

Books and Pamphlets.

THE MEDICAL PROFESSION OF UPPER CANADA, 1783-1850. An Historical Narrative, with original documents relating to the profession, including some brief biographs, by Wm. Canniff, M.D., M. R. C. S., Eng. Illustrated. Cloth. 1894. Toronto: Wm. Briggs.

This work is divided into three parts. The first part deals with the Pioneer Medical Men, and the several steps taken to establish the profession on a legal basis. The second part includes the proceedings of the Upper Canada Medical Board from its organization in 1819, to 1850; and of the College of Physicians and Surgeons of Upper Canada, 1839-41. The third part contains biographical sketches of early physicians of the Province, with many references to early events in the history of Upper Canada. A number of cuts of the more prominent members of the profession add considerably to the beauty and value of the book. The preservation of the records of the medical fraternity is a most praiseworthy object, and deserves the hearty co-operation of every medical man. The book contains six hundred and eighty-eight pages, which are filled with matter of interest to the medical profession of Ontario. The success which we feel must await the author in this undertaking, and which he truly deserves, will, we trust, repay him amply for the valuable time he has spent in bringing this work to completion.

ANTISEPTIC SURGICAL TECHNIQUE with especial reference to Gynæcological operations, together with Notes on the Technique employed in certain supplementary procedures. By Hunter Robb, M.D., Associate in Gynæcology, Johns Hopkins University; Professor of Gynæcology, Western Reserve University, Cleveland, Ohio. Illustrated. Philadelphia: J. B. Lippincott Co. 1894. Price \$2.

This work contains 250 pages, replete with useful and important information concerning anti- and asepsis in surgical proceedings, both major and minor. While much space is necessarily devoted to the description of appliances and procedures which one could only hope to command in hospital practice, there is an excellent chapter on "Operations in the country, in private houses, or in places where the technique must necessarily be more or less imperfect."

Doubtless the technique is grand, and the chance of infection reduced to a minimum by strict attention to its details; yet, in the preparation of the operator and his assistants, we cannot agree with Dr. Robb *in toto*. By the continued use of the permanganate of potash and oxalic acid, followed by strong solutions (1 in 500) of bichloride of mercury, as he recommends, one's hands shortly become blackened, roughened, and covered with fissures, which must necessarily greatly increase the difficulties of thorough disinfection.

A SYSTEM OF GENITO-URINARY DISEASE, SYPHILIGOLOGY AND DERMATOLOGY. By various authors. Edited by Prince A. Morrow, A.M., M.D., Clinical Professor of Genito-Urinary Diseases, formerly lecturer on Dermatology in the University of the City of New York, Surgeon to Charity Hospital, etc. With illustrations. In three volumes. Volume III, Dermatology. New York: D. Appleton & Co. 1894.

This volume of nearly one thousand pages has been contributed to by twenty-seven of the most prominent dermatologists in Canada and the United States. Whether that is an advantage or not is a matter of opinion, many preferring a work written entirely by one man. However that may be, this book must commend itself to all, as it is well written and arranged, exhaustive, and in every respect up to date.

The classification of diseases of the skin has, owing to advances made in microscopy and bacteriology during the last few years, of necessity changed considerably. Some forty new diseases have been added, which, a few years ago, were either confounded with others or entirely unrecognized. This has necessitated the introduction of many new terms in order that pathological conditions may be more clearly explained.

This book contains what is most essential in a treatise on dermatology, viz.: good plates and photo-engravings. There are eleven photographs in colors or chromo-lithographs, sixteen half-tone plates, and one hundred and four figures, mostly photographs of pathological changes in diseased tissues. These have all been most beautifully and perfectly executed, and are life-like representations of what they are intended to illustrate.

AN OPERATING TABLE. By Hunter Robb, M.D. From the John Hopkins Hospital Bulletin, No. 41, June, July, 1894.

THE JOHNS HOPKINS' HOSPITAL REPORTS. Vol. IV., Nos. 4 and 5. Report in Neurology II. I. Dementia Paralytica in the Negro Race. II. Studies in the Histology of the Liver. III. Intrinsic Pulmonary Nerves in Mammalia. IV. Intrinsic Nerve Supply of the Cardiac Ventricles in Certain Vertebrates. V. Intrinsic Nerves of the Sub-maxillary Gland of the *Mus Musculus*. VI. Intrinsic Nerves of the Thyroid Gland of the Dog. VII. The Nerve Elements of the Pituitary Gland. By Henry J. Beekley, M.D.

THE SCHIMMEL NON-REPEATING PRESCRIPTION BLANK. H. J. Milburn & Co., Detroit, Agents.

This is a very novel and doubtless very useful form of prescription blank, arranged so that the patient cannot have a mixture refilled without first reporting to his physician and receiving his order.

MACROBIOTIC; OR, OUR DISEASES AND OUR REMEDIES. For Practical Physicians and People of Culture. By Julius Hensel, Physiological Chemist. Translated by Professor Louis H. Tafel, of Urbana University, Ohio. From the second revised German edition. Philadelphia: Boericke & Tafel. 1894. Pp. 6-7 to 201.

MYOMA UTERI AND ITS TREATMENT. By Andrew F. Currier, M.D., New York. Re-printed from *American Journal of Obstetrics*. Vol. xxix No. 1. 1894. Wm. Wood & Co.

THE INTRA-UTERINE TAMPON. By Andrew F. Currier, M.D., New York. Re-printed from *Annals of Gynecology and Pediatrics*. October, 1893.

NINETEENTH ANNUAL REPORT of the Secretary of the State Board of Health of the State of Michigan, for the year ending June 30th, 1891. Robert Smith & Co., State Printers.

ABSTRACT OF PROCEEDINGS of the Michigan State Board of Health Quarterly Meeting, July 13, 1894.

UTERINE PATHOLOGY. By E. H. Pratt, M.D., Chicago. Reprinted from the *Journal of Official Surgery*, June, 1894.

PROCEEDINGS AND ADDRESSES of the Sanitary Convention, held at Menominee, Michigan, April 5th and 6th, 1894.

ASEPSIS IN MINOR PROCEDURES. By Hunter Robb, M.D. Reprinted from *Maryland Medical Journal*, May 19, 1894.