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# THE CANADIAN PRACTITIONER

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## Original Communications.

### PYURIA.

W. H. B. AIKINS, M.D., L.R.C.P., LOND.

This communication presents in brief form the manner of treating gonorrhœa, acute and chronic, as taught by the Vienna school. The major part is a translation from a monogram written by Dr. Ultzman, entitled "Pyuria and its Treatment." I had the pleasure of attending Dr. Ultzman's clinique for three months, and saw very favourable results follow the treatment he advocates. When pus is present in the urine, either in large or small quantities, the condition receives the name pyuria. It is readily understood that with the term pyuria a diagnosis only in a general way is indicated. It is one of those expressions much used in the past, but with the development of medical diagnosis these general diagnoses are rarely made. For now a more accurate diagnosis can be made not only by the aid of more precise instrumental examination, but also by the help of microscopic and chemical investigation. Pyuria indicates that there is pus in the urine, a symptom not a disease.

The treatment of gonorrhœa differs according to the location of the disease and to the acuteness or chronicity of the same, and may be divided into (a) that for the spongy portion of the urethra (anterior to the musculus compressor urethræ) and (b) that for the prostatic portion (posterior to that muscle). Acute urethritis is usually

treated by means of injections, to this exception should be taken for experience has shown that in acute cases the treatment should not be local. Internal medication and the regulation of diet is of the utmost importance. On the other hand chronic suppuration should receive local treatment. Dr. Ultzman in his paper does not enter into the full details for the treatment of acute gonorrhœa, nor the uses of the endoscope, but considers the local and instrumental procedures, which he most approves in chronic gonorrhœa.

*Treatment for spongy portion of Urethra.*  
*Catarrhal Urethritis.*—Urethral inflammation, the result of accident, or produced by chemical influence, requires for its treatment; attention to diet, cleanliness of parts is of the greatest importance, and weak injections of alum, zinc or permanganate of potash.

*Gonorrhœal Urethritis* runs under favourable conditions, its course in four or six weeks; during this time the inflammation extends backwards, and ceases when no complication occurs at the musculus compressor urethræ. The treatment aims at allowing the process to run its course without complication, and to prevent the inflammation from spreading beyond the border of the compressor urethræ. If it does, very soon the bladder and other parts become involved. Individual disposition, diseased, and also senile conditions of the urinary apparatus play a great role in this relation. Frequently, it is observed, that the gon-

orrhœa in cavalrymen, who must be on duty, will run a favourable course, while in other cases, in spite of the greatest attention, most unpleasant complications take place; yet, the physician does his duty, when in addition to medical treatment he regulates with precision the manner of life of the patient.

The first gonorrhœa is usually the most painful. In subsequent attacks the inflammatory process is not so severe. On a recurrence of the gonorrhœa, it is desirable to adopt the treatment, which was previously successful. If the first gonorrhœa was complicated with cystitis or orchitis, the second and third will most probably show the same complication.

When possible the patient should remain quiet and live sparingly. If it is necessary that he be actively engaged a suspensory bandage should be worn, more particularly in the third and fourth weeks, when the inflammation is close to the compressor urethræ. A milk diet is the best; fruits and vegetables exert a favourable influence; meat must be avoided; indulgence in pickles, wines, beer, and spirituous drinks must be denied.

During the first week, if the inflammation is very severe, and the sensitiveness of the urethra great, cold applications are useful.

Internal medication in the treatment of gonorrhœa is of little value. Gonorrhœa is a local inflammation of the urethra, and not a constitutional disease, consequently, it appears that general treatment through internal medication is aimless. The use of large quantities of copaiba, cubebs, and similar remedies, is not a matter of indifference, for by the administration of these drugs the digestive system suffers, an erythematous eruption may appear, albuminuria may be produced, and epididymitis more frequently occurs after treating gonorrhœa by large doses of copaiba than in those cases where purely local treatment was adopted. Small doses

are useless; the drug is too much diluted in the urine to exert a curative effect on the mucous membrane of the urethra. Large doses are hurtful; therefore, it is better not to treat gonorrhœa by internal medication, but to rely entirely on local treatment. If copaiba, cubebs, oil of sandal wood, and the other remedies of this class are thought to act so beneficially on the mucous membrane of the urethra, when in part secreted with the urine, and coming into contact with the urethra during micturition, why not choose the shorter way, and bring the remedies in direct contact with the diseased surface in the form of injection?

Acute gonorrhœa always begins at the meatus, and gradually passes backwards to become concentrated in the bulbous portion. It appears enticing to energetically push local applications in the early stages in every possible way to choke the whole process in the germ. Different abortive methods have been tried but none are to be chosen. When it is established that gonorrhœal infection depends upon a contagious micro-organism, then abortive treatment with a germicide will be in order.

If the inflammation at the onset is severe and painful, even weak astringent solutions are not well borne. In such cases injections either of cold water or a weak carbolic acid solution may be used. If the urethra is not very sensitive, mild astringent solutions can be commenced with, such as alum and zinc sulph.  $\bar{a}\bar{a}$ . gr. i. ad  $\bar{z}$ l., potass. permanganatis gr. 1/24. aq.  $\bar{z}$ l. The solutions should be used from three to six times a day according to the amount of the secretion. The patient should urinate before every injection to clear away the purulent secretion from the urethra. At first, half a syringeful of the remedy is to be injected and immediately allowed to flow away. Two to four injections can be used one after the other. Later on in the second or third weeks a syringeful of the solution can be

easily forced into the urethra and allowed to remain in for one or two minutes with the meatus closed. In the majority of cases according as the secretion and sensitiveness of the urethra indicate, the injections are to be increased to two or three times their strength and kept so till they are no longer required. Use may also be made of tannin alone or in combination with alum. Injections composed of drugs such as sulphate of zinc or acetate of lead which do not dissolve but are suspended in water have the disadvantage that the fine powder is deposited and stops the orifices of the urethral glands, and may cause small follicular abscesses. Some days after using such injections, it is observed that cylindrical plugs composed of the precipitate are discharged during micturition. It is well to use only clear and filtered astringent solutions. To prevent painful erections and chordee, it is well to prescribe bromide of potash, lupuline, and keep the bowels freely open.

When the gonorrhœa lasts more than eight or ten weeks, it is called chronic—chronic gonorrhœa consists in this, that spots on the mucous membrane do not become covered over with epithelium, but continue to secrete. Grünfeld considers that occasionally small polypoid excrescences occur when the disease become chronic. The chronic gonorrhœa process is not always confined to the superficial mucous membrane, frequently the deeper layers are involved, and when the deeper layers of the diseased parts show cicatricial changes, rigidity of the urethral wall and cicatricial contraction will take place and unpleasant symptoms follow. To aim at a complete cure, the lumen of the urethra as well as the walls of the same must be made normal. It is useless to employ simply astringents and caustics to bring about the restoration of the parts. The normal male urethra is a soft elastic sheath into which can be passed with ease, a catheter having the calibre of number 30 Charrière scale, the

meatus is usually more or less contracted and may have to be divided before it allows of the passage of so large a sound. In a case of chronic gonorrhœa when the urethra is examined with a thick sound, it is found that the diseased portion is narrowed, and the large sound will not pass at all or only with difficulty. The slight lessening of the urethral lumen or the loss of elasticity of the walls of the urethra cannot be proved with small instruments, still less can it be improved; not only must the inflammatory process on the superficial portion of the mucous membrane be cured, but also the lumen and elasticity of the urethra must be brought to a normal standard. If this latter is not attended to, constant irritation of the peripheral endings of the nerves of the urethral wall results, and there arises after gonorrhœa either a neurosis in the genital region or that moisture of the urethra called false prostaticorrhœa, which appears to be due to the difficult circulation of the blood in a rigid urethral wall; looking at it from this standpoint the treatment of chronic gonorrhœa by means of the thick sound is a *conditio sine qua non*. In many cases sounding alone produces a complete and permanent improvement. The sound cure is carried out in this way, to begin with small numbers and gradually increase them according to the Charrière scale, every day or every other day introduce the next largest instrument and allow it to remain in for a minute, increasing till number 27 to 30 and upwards is reached. If the sounding is discreetly performed it is observed that the secretion soon decreases. If sounding is not sufficient injections can be employed in addition, making use of them immediately after sounding.

In these cases the bougies and also the other instruments should be rubbed with glycerine and not with oil, because when the urethral walls are covered with fat, watery solutions of astringents or caustics do not come in direct contact with the mu-

cous membrane, and are therefore inefficient. The remedies can be applied in the fluid, semi-fluid or solid forms. The fluid can be made use of in the dilute or concentrated form. As an injection the dilute form is best. The so-called deep injection or irrigation of the anterior portion of the urethra should be carried out in the following manner. The patient standing, a soft catheter with calibre No. 14 (Charrière scale) having two side openings, is introduced as far as the bulbous portion, the patient holds a vessel in the right hand and the catheter in the left, slowly force the solution in by means of a hand syringe, the medicated fluid flows out from both openings of the catheter into the bulbous portion of the urethra, and on account of the contraction of the compressor urethra cannot pass into the prostatic portion, but flows along the side of the catheter out at the meatus. The object of this irrigation is to bring the injection in its full strength in contact with the bulbous portion of the urethra, the choice seat of chronic gonorrhœa. Various astringents can be employed. The irrigation causes no pain and can be used once a day. The fluid in the concentrated form, which acts as a caustic, can be brushed on the parts. The apparatus to be used for this purpose consists of three pieces made out of hard rubber: (a) straight endoscopic tube; (b) guide for same; and (c), the brush. The calibre of the tube is Charrière scale 20-22. The brush is fitted with a screw movable on the shaft, and can be arranged so that the whole or only a portion of the hair of the brush will project beyond the end of the tube. To be used in the following manner: the patient lying, the straight endoscopic tube containing the guide is rubbed with glycerine and gently passed into the bulbous portion; the guide is then removed, and the brush saturated with the medicated fluid is introduced, the brush and tube are held in one hand, and being withdrawn, are rotated. This can be repeated till the bulbous portion is well

brushed over. When one is accustomed to the use of the endoscope the spots can be seen before the brush is introduced. Solutions of silver nitrate gr. i. to the ounce, or a still stronger solution may be used, most frequently a five per cent. After the parts have been brushed with this solution, and the endoscope introduced, the diseased portion of the urethral mucous membrane is found to be of a greyish white colour, while on the normal part there is but slight change in the colour. The brushing can be done every second day. On its application the patients feel a slight burning, which soon passes away. Suppositories may be used; they are of two kinds, the long and short. The long suppositories are usually prescribed in order that the patients may use them themselves; the short suppositories are 2 c.m. long; they can be introduced into the deeper parts most readily when using the straight tube or the guide. They can be made either from cocoa butter or from gelatine; those most frequently made contain zinc, copper, or tannin. One can be used every day. The short suppositories should be placed in the bulbous portion when the patient is lying down. After one is introduced the patient remains quietly lying, or, if he must move around, the penis should be bound against the abdominal wall to prevent the dissolving suppository from coming away. It should remain at least half an hour in the urethra before the patient is allowed to micturate.

Medication in solid form consists either of powder or dried paste, usually alum or tannin mixed with sugar is blown through the straight endoscopic tube into the urethra. It must be also mentioned that there are certain forms of urethral inflammation which do not yield to this local treatment, where there is a certain dyscrasia, constitutional treatment must be used, for example where there is syphilis antisyphilitic measures must be adopted. In tuberculosis change of air and removal to a country with warm winters is followed

in some cases by a cessation of the discharge.

*Urethritis of the prostatic portion behind the Compressor Urethrae.*—The treatment for acute catarrh of the prostatic portion must be entirely dietetic and medicinal, instrumental treatment is not to be thought of. Chronic catarrh of the prostatic portion usually follows obstinate gonorrhœa and it is also found in certain persons who have been addicted to practice masturbation and in those who have led a dissolute life and indulged in sexual excesses. The catarrh appears also primarily in beginning tuberculosis of the prostate and in wounds of the bladder and genital apparatus. In treating chronic catarrh of the prostatic portion it is desirable to bring the remedy into direct contact with the diseased urethral wall. The manner of employing the remedy differs according to whether the dilute or concentrated form is used, a mode of irrigation is the best for the dilute form. The irrigation catheter is made of silver, 16 cm. long and corresponds to No. 14 or 16 of the Charrière scale. The vesical end has the ordinary curve of a metal catheter and is provided with several openings. To the extra-vesical end is attached a disc which is marked and shows the direction of the bill of the catheter. Joined to this end is a rubber tube 20 cm. long which is in attachment with a syringe. If the catheter is in proper position the fluid runs into the bladder without resistance. The internal sphincter is such a weak muscle that it offers no opposition to the entrance of the fluid into the bladder. If the catheter is not in the membranous portion the fluid flows back around the catheter and out at the meatus. Immediately after the injection allow the patient to completely empty his bladder. This is only to be commended when the bladder is capable of complete contraction, of voiding even the last drop. If the bladder is insufficient a quantity of the injected fluid remains behind and may cause painful irritation and other evils.

For an insufficient bladder the irrigation of the prostatic portion with an ordinary elastic catheter is much better. To carry this out the patient stands, allow him as far as possible to empty the bladder then introduce into the bladder an elastic catheter with two side openings. The quantity of fluid drawn off with the catheter shows the amount of insufficiency; when the bladder is emptied, the catheter is withdrawn somewhat till the openings at the end lie in the prostatic portion, then inject a quantity of the medicated fluid into the bladder, after injecting a sufficient quantity in this way the catheter is reintroduced and the bladder completely emptied.

It is important that the solutions should be warm when injected.

Another instrument is used when it is desirable to act on the parts with remedies more caustic than astringent. It consists of a short, thick walled curved catheter, with a capillary tube of fine silver. Attached to the extra-vesical end there is a piece of hard rubber fitted to receive the end of a small Pravaz syringe, the tube contains but two drops, if we wish to inject one drop of a concentrated solution into the prostatic portion three drops must be drawn into the syringe, if we wish to inject two drops four drops must be in the syringe.

In using this apparatus, the patient lying, the syringe is filled with three or four drops of the solution and is adjusted in the catheter already in place in the prostatic portion. In order to ascertain if the point of the instrument is in proper position one finger can be introduced into the rectum, immediately after injecting a burning sensation is felt in the urethra, it is advisable after using this instrument for the patient to remain lying for an hour or so. The five per cent. solution of silver nitrate is most generally used, when a ten per cent. solution is injected it is commonly followed by more or less bleeding from the cauterized part, the weak solution can be used every second or even every day, while

the strong solution should be used at most twice a week. This plan of treatment is good for mild cases of catarrh of the prostatic portion occasioned by masturbation, and after sexual excesses associated with discharge of semen, and is of the greatest use in spermatorrhœa and also in catarrh of the prostatic portion following gonorrhœa. The cauterization of the prostatic portion finally may be done with nitrate of silver in substance either by means of Lallemand's caustic holder, or much better by using the endoscope when the parts are under the control of the eye.

### SUB-DIAPHRAGMATIC ABSCESS.

J. M. COCHRANE.

C. F., æt. 23, a native of England, a man of temperate habits, unmarried, and having recently arrived in this country from England, where he had been employed in labouring work in the lumber docks. Admitted to the Toronto General Hospital on January 26th, 1884.

The family history contained nothing of importance, no facts pointing to tuberculous or other diseases could be ascertained.

The patient's early history showed that he had never been a strong man. In early infancy had some of the diseases of childhood, though nothing very serious till about the age of five when he had an attack of scarlet fever, from which recovery seemed to be slow.

About three years ago the patient suffered from some trouble of the liver, the exact nature of which could not now be ascertained, and for which no special treatment, beyond some liver complaint nostrum, was employed. The disease was short, and with the exception of very occasional and slight returns did not trouble the patient much till about three months ago, when the pain was again felt severely, but it soon passed away.

On admission to the Hospital, the patient complained of pain in the right

side. There was slight cough and expectoration. There was dullness on percussion over the right lung extending nearly half way up from the base, no indications of cavities were noted. The left lung seemed to be unaffected.

Within two or three days of admission the extent of dullness of right lung increased upwards, the cough became much more frequent, and was accompanied by a fœtid expectoration, the sputa were purulent, viscid, and sometimes streaked with blood. In the later stages of the disease it was expectorated in unusual quantity, sometimes masses of pus were brought up, unaccompanied by coughing or voluntary effort.

The patient was again examined a week later, and the present history then taken (Feb. 9th.) The symptoms above mentioned were much increased, the cough and expectoration constant. The patient was much emaciated and distressed, there was great œdema of the feet and legs, the sitting posture was the only one in which the patient could remain with comfort. The breathing was difficult; the hearts' action tumultuous; the pulse registering 134; the temperature 103.5 at 6 p.m.

Examination indicated dullness, fully half way up the lung on the right side, there was also some dullness in a limited area at the base of the left lung, the apices of both seemed to be clear, coarse rales were noted at the right base, and a peculiar click was heard irregularly on expiration.

The dullness marking the extent of the liver was found lower than normal, and was continuous above with the dullness at the base of the right lung.

The temperature during the last six days of the illness varied between 100° and 102.5, the pulse was almost uniformly 110 in the morning, 130 at night.

Within the last two or three days, severe pain referred to the heart was felt, the indications were considered as those of

pleural complication, and the usual local applications were made.

The general treatment pursued was palliative towards pain and cough; a mixture of creosote, tincture iodine, and tincture benzoin com., vaporized, was used with much relief. Internally, pot. chlor., tinct. ferri. mur., and quinia, were given every four hours in fairly large doses. Stimulants and nutritious diet were prescribed.

The diagnosis of this case was based on the somewhat unusual situation of primary dullness of the lung; its continuity with that of the liver; on the supposed enlargement of the liver, with the previous history of liver trouble, and specially on the forced upright position of the patient, sensations of choking with pus being felt on recumbency, and the actual greater frequency of expectoration when in that position. On the râles, and peculiar valvular click heard at the right base, and the frequent discharge of masses of unmixed pus; all of which seemed to the writer to indicate hepatic abscess, opening into the right base and finding exit through the air passages.

The patient rapidly became weaker and died on the 16th Feb. The *post mortem*, was held on the following day by Dr. Graham.

*Thorax.* The pericardium contained a large amount of serous effusion. The heart was hypertrophied and filled with blood, an ante-mortem clot was attached to the mitral valve, other valves healthy, the endocardium stained with pigment, right ventricular walls thinner than normal; weight of heart  $12\frac{1}{2}$  oz.

*Lungs.* Pleuritic adhesions on the left side, the left lung was found to contain a small abscess near the lower margin filled with pus, in the upper lobe another small abscess was found, the smell and appearance of which indicated gangrene.

The right lung, upper lobe œdematous, and congested, the tubes filled with pus in the lower portion, the lower lobe also con-

tained pus, and near the base was found a small cavity. There was also caseous degeneration and marked tubercle.

*Liver.* Left lobe much hypertrophied, slightly fatty, otherwise healthy. Right lobe, not extending as low down as normal, presenting nothing abnormal on section, but on the upper surface was found a large abscess, bounded above by the diaphragm, below by the hepatic capsule, and laterally by firm adhesions of the diaphragm with the capsule of the liver to the extent of three or four inches in diameter, in an irregular oval. At the uppermost part of this cavity, was an irregular opening about an inch in diameter, piercing the diaphragm, and the basement membrane of the lung, and connecting with the cavity noted in the base of the lung, the cavity being filled with pus.

The capsule of the lung was much thickened. The kidneys were congested, capsules, non-adherent.

The spleen much enlarged, and congested, other organs normal.

The discrepancy of position of lower border of the liver, before and after death, may possibly be accounted for, by the pressure at the former time of an accumulation of pus in the large cavity, pressing the lobe downwards; though it may have been an error in examination, as percussion and manipulation seemed to increase the distress of the patient.

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### Selections: Medicinc.

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**AORTIC STENOSIS.**—I have long recognized that, while a systolic aortic is one of the commonest of the valvular murmurs, actual narrowing of the orifice is the most rare of the valvular changes.

A systolic aortic murmur may be due to several causes, which will now be enumerated.

1. Anæmia may be mentioned first. It is not well understood how it is that watery blood, deficient in corpuscles, gives rise to murmurs; but the fact is exemplified by the venous hum heard in the neck, by the pulmonary murmur, and also, though less

commonly, by a systolic aortic murmur; this accompanies the first sound, and does not substitute itself for it. With this anæmic aortic murmur may be grouped the hæmic of very similar character, which sometimes accompanies or follows acute febrile disease of long duration, such as typhoid and rheumatic fever.

2. Mere roughening of the orifice or valves, or impaired flexibility of the latter, slight congenital malformation, fenestration of one or more of the cusps, a shred of fibre hanging from the edge of a valve, may give rise to a loud systolic murmur, without offering the least obstruction to the course of the blood.

3. Dilatation of the aorta just above the valves, the orifice and valves remaining unchanged, produces a murmur; the blood passing through an aortic opening of normal size into a larger cavity beyond is thrown into eddies, the vibrations of which produce a sound heard as a murmur. In none of the above mentioned conditions is there stenosis of the orifice or obstruction to the stream as it issues from the heart; the condition last named has dangers of its own, but they do not arise from aortic obstruction.

4. Acute narrowing of the mouth of the aorta is almost always due to changes in the valves, the cusps of which may be stiff and rigid with rounded and thickened margins; or adhesion may have taken place between the valves at the angle in which they meet; or, without being greatly thickened, the valves may be affected with atheroma, which destroys their flexibility, and puckers and contracts them, and may go on to calcification.

5. It is also possible, that, by dilatation of the ring at the root of the aorta, valves, not themselves greatly diseased, may be so put on the stretch that they cannot fall back, but remain as an obstacle to the stream of blood.

It is clear that the first point to be ascertained, when a systolic murmur is present, is, whether it indicates the existence of obstruction or not; in this we shall be greatly assisted by the history and existing condition of the patient. We should conclude that the murmur was hæmic when there was marked anæmia, or if the patient were convalescing from an acute illness, especially if murmurs were heard at other valves as well. A systolic aortic murmur

appearing at middle age or in advanced life will seldom be due to actual narrowing of the orifice, but will be caused by roughness or rigidity of the valves, or by dilatation of the aorta above the valves with perhaps atheromatous irregularities in its walls. The significance of such a murmur at this period of life varies enormously; it may be produced by a harmless bag of fibre, or it may indicate aneurism of one of the sinuses of Valsalva, but it is rarely that as actual obstruction that injury results. The loudness or character of the murmur does not give us much help; hæmic aortic murmurs are usually soft and smooth, but so also may be murmurs due to extreme narrowing, especially when there is weakness of the ventricle and languid propulsion of the blood; thus the gradual enfeeblement and ultimate disappearance of a systolic aortic murmur, may be a most serious prognostic fact.

We turn now to the changes in the condition of the heart produced by aortic stenosis. The change, by which aortic obstruction will be overcome, will be hypertrophy of the left ventricle. The physical signs, therefore, of this hypertrophy, the position and character of the apex-beat and impulse, and the modifications of the sounds will enter into the diagnosis of actual narrowing of the aortic orifice. The character of the aortic second sound may aid in distinguishing hypertrophy compensatory of obstruction from the hypertrophy attending renal disease; it will usually be indistinct in the former, and always accentuated in the latter case. Almost more important than the hypertrophy of the left ventricle, will be the character of the pulse. The pulse-wave will be long and slow; the artery will be small and full between the beats of the pulse; a large sudden pulse is incompatible with aortic stenosis unaccompanied by regurgitation; and when it is a question whether or not an aortic systolic murmur is due to obstruction at the orifice, the pulse becomes the most certain criterion to which we can appeal; if there be an apparent contradiction between the indications of the heart and those of the pulse, the latter must dominate. Even when there is co-existing aortic regurgitation, which tends to render the pulse large, sudden and collapsing, the development of these characters is interfered with by stenosis. Nearly all authors concur in making aortic

stenosis the least dangerous of the valvular affections, and, on *a priori* consideration, such would seem to be probable, but this conclusion will scarcely seem quite secure, if the cases of systolic aortic murmur, without actual narrowing of the orifice, are eliminated; the relative danger of real stenosis cannot, without further experience and inquiry, be estimated with confidence; but it is certainly greater than has been supposed.

As a rule, aortic stenosis proves fatal by the slow operation of dropsy, and for the most part mitral regurgitation is present either as a secondary consequence of dilatation, or, as an independent affection produced by the endocarditis which damaged the aortic valves. So long as the obstruction at the aortic orifice is uncomplicated by mitral change, the danger attending the disease will not be imminent. The secondary changes will take the well known backward course. Beginning with the hypertrophy, there will follow dilatation of the left ventricle, favoured by anæmia or any other form of debility; then will come systemic stagnation, from diminished propulsive power in the ventricle; and sooner or later there will be regurgitation through the mitral valve, resulting either from the dilatation, or from actual lesion of the valve or its tendinous cords, produced by the increased pressure consequent upon the powerful contraction of the ventricle, or from the combined operation of these two influences. This marks a downward step, and makes the prognosis grave. It further appears to me that, dropsy having once set in, there is a smaller probability of recovery than in most other valvular affections, it being always understood that when this complication has been prematurely induced by exposure or exertion there is some hope that it may be successfully combated and warded off for a time.—W. H. Broadbent, M.D., F.R.C.P., in *Brit. Med. Jnl.*

FACIAL ERYSIPELAS.—Looking at the patient before you, the swollen condition of the ear and neck, and the inflamed integuments of the face, the diagnosis is made at once. You will say that we have to deal with a case of facial erysipelas—a specific inflammation of the integument of this portion of the body. This is often preceded by glandular swelling of the neck. Let me

here give you a practical point in regard to the recognition of this disease before the appearance of the erysipelatous inflammation. Very often before there is any other evidence of the trouble, without, it may be, some constitutional disturbance, there will occur swelling of the glands of the neck. Upon such an appearance, you may base a diagnosis of erysipelas, in advance of the appearance of the malady, provided there is evidence that the tendency to the disease is present in the atmosphere.

Every case of erysipelas has importance, although a single case like this is *per se* of little moment. This is a self-limited disease. It will go through its several stages, and disappear without interference. Notwithstanding the fact that it is a self-limited disease, no case should be underrated. It is of importance, because there is in this affection danger of cerebral embolism. This is followed by violent delirium, terminating in coma and insensibility. This accident is by no means common, but it may occur in any case, especially if the individual has been rather given to his cups.

Why may this cerebral embolism be expected to occur in any case of facial erysipelas? A moment's consideration of the anatomical relations of the parts will furnish the explanation. The facial veins which return the blood from the skin communicate with the pterygoid plexus and cavernous sinus. In other words, the blood, instead of being returned from the superficial parts by superficial vessels, passes within the skull and communicates with important veins within the cerebral cavity. Hence it is that there may occur in facial erysipelas, the serious complication of cerebral embolism. No case should be neglected, although almost every one goes through its course without any complication.

The treatment should always be conducted with reference to such a possible complication, and with reference to the systematic condition of the patient. In an ordinary case, it will suffice to place the patient at rest, order a suitable diet and keep the bowels open; but if the case is more serious, there are three remedies which may be used with advantage. The first is belladonna. This drug produces a condition of the skin and vessels directly in antagonism to that which exists in erysipelas. You will often be surprised to see how speedily the erysipelas disappears after the development

of dry mouth, dilated pupil and flushing of the skin.

If there be any systemic depression, as there usually is in severe cases of facial erysipelas, quinine should be combined with the belladonna, giving one-quarter of a grain of the extract of belladonna with from two to five grains of sulphate of quinia every three or four hours.

Should we have reason, from the occurrence of delirium or the beginning of coma, to suspect that emboli were being deposited, we should, without delay, resort to the use of carbonate of ammonia and produce full alkalization of the blood as speedily as possible. Such are the general principles of the systemic management of these cases.

What local measures should be employed? The text-books contain a vast variety of remedies to be applied locally. The attempt is made to stop its spread by the use of blisters, nitrate of silver, tincture of iodine, a saturated solution of the sulphate of iron, carbolic acid and a thousand and one other remedies. All this is based upon a fallacy. This condition of the skin is a symptom of the malady and only a symptom. We cannot, as a rule, prevent the spread of the disease by the remedies mentioned. We cannot prevent or limit by such measures the constitutional condition. The simplest local application suffices. I have seen more good from mercurial ointment very much diluted, and from vaseline or lard, than from the most elaborate applications. The strength should be one drachm of mercurial ointment to the ounce of lard or vaseline. If there is reason to fear that the disease will exist as an epidemic, we should, of course, adopt measures to prevent the diffusion of germs. In a simple case like the one before you the proper treatment is that which I have indicated.—*Coll. and Clin. Rec.*

**DELIRIUM TREMENS.**—It has long been a matter of dispute whether delirium tremens is due to the direct poisonous action of the alcohol or whether it is due to the sudden stopping of drinking, and hence to the sudden withdrawal from the system of its accustomed stimulant. There can be no doubt that in many cases delirium tremens is caused directly by drink. Many patients have entered the hospital during my term of service in a wild condition of delirium tremens who have continued to drink up to the very hour of entrance. On the

other hand, a number of patients have entered the hospital in a drowsy, stupid condition brought on by drink, and it was not until a day or two later that delirium tremens proper came on. In these cases it might seem as though the delirium tremens did not appear until the drink was withdrawn and then appeared in consequence of this withdrawal. It is well known that drunkards can put off an impending attack of delirium tremens by continuing to drink, but whether they can thus postpone the attack indefinitely is a matter of doubt; judging from my limited experience I should say not. After a time the stomach is apt to get into such a condition that it will no longer retain alcoholic drinks; but even in those cases where the stomach will tolerate the alcohol, still the attack of delirium tremens will sooner or later come on and cannot be indefinitely postponed by drink. The opinion that delirium tremens is caused directly by the drink and not by its withdrawal has of late years gained more and more ground, and at the present time I think the great majority of those who have had much experience in the treatment of delirium tremens incline to this view and hence believe in stopping all alcoholic drinks immediately, instead of gradually diminishing the quantity of them, as has been advocated by those who believe that the withdrawal of the alcohol is the cause of the disease.

The question is somewhat different in the case of injuries. When an habitual drunkard, who has enfeebled his nervous system as well as all the other organs of his body by the long continued abuse of alcohol, receives some severe injury, he soon afterwards becomes tremulous and delirious and passes into a condition of very dangerous exhaustion. Now, this form of delirium tremens may perhaps in part depend on the sudden withdrawal of the usual alcohol stimulant, but it depends, it seems to me, in much greater part on the shock which the injury produces upon the enfeebled nervous system and on the extra work incident to the process of repair which is thrown upon the enfeebled and diseased internal organs, especially upon the kidneys. In this form of the disease it seems necessary to administer alcohol in some form, although I am inclined to believe that digitalis would be a better stimulant to the heart and kidneys in these cases.—*Med. Annals.*

**ALCOHOLIC LEG PAINS.**—T. Clifford Allbutt, writes to the *Brit. Med. Jnl.* These pains are so characteristic and so often met with that I feel surprise that they have received but little attention. These pains are commoner in women than in men, they are often tibial in distribution but also often occur about the ankles and feet. They are usually associated with marked cutaneous hyperæsthesia. I have diagnosed in women many a case of secret drinking by these pains alone. Indeed, if a woman were found to complain bitterly of pains in the legs below the knees, pains somewhat nocturnal in occurrence and as severe as those of syphilitic periostitis, if she resented any free handling of the limbs, if again she lay with legs adducted, extended, and with the feet pointed, much as in lateral sclerosis, but without permanent rigidity; if for all this outcry there were no visible cause whatever, the tibiæ smooth, and no more sign of spinal disease than perhaps a slight ankle clonus, then I should almost without hesitation, infer that alcohol was the cause. They can be cured only by abstinence.

**SYPHILITIC FEVER.**—Dr. Duflocq relates the history of a young man, twenty-five years of age, who was admitted to a hospital suffering from a fever. The attack had begun eight days previously with headache and vertigo followed by vomiting, after which fever and diarrhœa came on. There was also epistaxis a few days later. On admission the patient presented nearly all the symptoms of typhoid fever; the tongue was white; there was tenderness on pressure in the right iliac fossa, though the belly was not tympanitic; the spleen was slightly enlarged; heart and lungs were healthy. The temperature was 104.7°. The eruption of rose-colored lenticular spots was confluent over the abdomen, and very thick over the arms, legs, and thorax. They were large, slightly elevated, and disappeared momentarily on pressure. It was the great extent of this eruption that excited suspicion and led to further examination. A cicatrix resting upon an indurated base was found upon the glans penis, and there were enlarged glands in the mouth and fauces. The patient was placed upon ordinary anti-syphilitic remedies, and the fever and eruption disappeared in about two weeks. Dr. Duflocq mentions, as of diagnostic value in the differentiation of typhoid from syphilitic

fever, the early appearance (third or fourth day) and the abundance of the eruption.—*Med. News.*

**PAINFUL REFLEX IN THE ULNAR NERVE IN GASTRO-INTESTINAL AFFECTIONS.**—M. Treille says that in certain chronic affections of the digestive tube, as dysentery, palpation and strong pressure in the left iliac fossa will produce painful sensations and troubles of innervation variable in intensity and character on the back of the hand and the ring finger. Pressure is made with the fingers of right hand pressing on the abdominal wall towards the anterior superior iliac spine bringing the fingers up and towards the umbilicus at the same time depressing the integument. Weak induced currents applied three finger breadths internal to the iliac spine on the line proceeding to the umbilicus, will immediately produce a series of discharges in the ulnar nerve. M. Treille has noticed this phenomenon in so many dysenterics and gastralgics that he believes it to be constant. He can produce it upon himself by slight pressure. He found it in a saturnine gastralgie. This ulnar reflex may consist in hyperalgesia and hyperæsthesia to which anaesthesia sometimes succeeds, of a portion of the skin innervated by the ulnar nerve. The best means of causing the disappearance of this pain is to cure the intestinal affection.—*L'Union Méd.*

**PYREXIAL SYPHILIS.**—Dr. Burney Yeo gave the particulars of this case to the Clinical Society (*Brit. Med. Jnl.*). The patient had symptoms of pyrexia—high temperature, with great diurnal fluctuations, twice reaching 105° F. and four times 104°, and averaging in the evening for three weeks from 103° to 104°. The daily oscillations were often more than 6°. The other symptoms were pains in the limbs and trunk, headache, thirst, sleeplessness, great debility and rapid emaciation. Between a fortnight and three weeks after admission, symptoms appeared, chiefly on the back and legs, resembling imperfectly developed variolous pustules without the areola. He confessed that he had venereal sores on the penis. Anti-syphilitic treatment was attended by a rapid fall of temperature to normal, rapid improvement of nutrition and recovery of strength, and rapid drying up of the pustular eruptions.

**DANGERS OF LARGE DOSES OF QUININE.**—Dr. Smith, in the *N. Y. Med. Jnl.*, writes upon the danger of large doses of quinine in hyperpyrexia, with special reference to the treatment of typhoid fever. He says that in cases with a tendency to heart failure it is dangerous. Heart failure may be due to degeneration of the heart muscle, or to failure of nerve energy. There are two types of fever in which these causes of heart failure generally appear: the short, as in acute pneumonia where heart failure is liable to occur from the third to the sixth day: and the long, as in typhoid, where heart failure occurs usually from the second to the fourth week. A large dose of quinine twenty or sixty grains at once or within an hour, certainly has a depressant effect on the heart, and this should always be carefully examined before administering the drug in such doses. It is also well to guard it by small doses of opium or digitalis or ammonia. In the same journal Dr. Wright reports a case of pneumonia in an adult in which fifty grains of quinine were given in twelve hours. The temperature fell 9° to 93° 4/5, collapse ensued, but by the exhibition of heart stimulants recovery finally took place. Another case is reported of a boy with intermittent fever who took 128 grains of cinchonidia, followed by collapse and death.

**WASHING THE STOMACH IN NURSINGS.**—Dr. Epstein, of Prague, for some years practiced washing of the stomach in nurslings. In this manner he treats acute stomachal catarrh, the first period of cholera infantum, and in a word all those gastric conditions accompanied by vomiting, and rapidly producing marasmus. In case of poisoning, washing is equally indicated. The operation is simple; more simple than in adults. A soft rubber sound is used—number eight or ten—terminating with a glass tube—to which, after introduction, another elastic tube, bearing the funnel, is attached. The length of the pharyngo-oesophageal canal in a child 50 cm. in height is about 18 cm. The child is laid on its back, the finger presses back the tongue, and guides the tube, which is easily swallowed. The washings are done with magnesian or sodic water. It is suggested in atrepsics to feed artificially in this way.—*Journal de Méd. de Paris.*

**ACUTE SUB-UMBILICAL PERITONITIS.**—Mr. Goix, (*Jour de Méd. de Paris*) says that acute sub-umbilical peritonitis is manifested clinically; (a) by the general symptoms common to every acute peritonitis; (b) by local phenomena peculiar to it, which are a superficial pain limited to the sub-umbilical portion of the abdomen, retention of urine and intestinal meteorism; (c) by a very important negative sign, the integrity of the diaphragmatic respiration. From acute perityphlitis it is distinguished by the absence of the œcal and pericœcal swelling, and from sub-peritoneal phlegmon by the preservation throughout the duration of the disease of the normal mobility of the skin on the subjacent layers. In phlegmon the subcutaneous tissue of the abdomen always participates secondarily to the inflammation and the skin loses its mobility.

**RELATION OF DISEASES OF THE ABDOMEN TO THOSE OF THE RIGHT HEART.**—Passerini, (*Gaz. degli Ospitali*) mentions three cases of tricuspid insufficiency consecutive to a peritoneal effusion. On auscultation there was heard a prolongation of the first sound and a murmur; the second sound was intensified over the pulmonary orifice. The disappearance of the peritoneal effusion caused the cessation of these sounds. The abdominal effusion acts mechanically by compression, causing venous ischaemia of the viscera and overloading, and hyperæmia of the thoracic organs. In pregnancy and in ovarian cysts, and by simple pressure upon the abdominal walls, these abnormal bruits have been called into existence.—*Jour. de Méd. de Paris.*

**NON-VESICATING CROTON OIL.**—Harold Senier, of the London Chemical Society, states that when alcohol of the specific gravity of 0.794 to 0.800 is added to croton oil in the proportion of seven or more volumes to six, the oil separates into two parts, one of them (the vesicating oil) dissolves in the alcohol and remains soluble in alcohol in all proportions; the other (the purgative oil), separates and is then found to have become insoluble in any proportion in alcohol. The insoluble oil is said to be a safe and pleasant purgative free from any undesirable action, in doses of one-tenth to one-half a minim, in the form of pills made with magnesium carbonate and extract of henbane as excipients.—*N. Y. Med. Jnl.*

**ANTIPYRETICS IN TYPHOID FEVER.**—Dr. Beverley Robinson (*ibid*) criticises the use of antipyretics in typhoid fever. He maintains that high temperature is not necessarily a bad symptom, the well known agents cold, quinine, salicylates, etc., will lower the temperature for a while, but to keep it down will have to be continuously administered. Quinine acts by lessening cardiac power and tends to produce visceral congestions. The salicylates are depressant to the heart and disturb the stomach. Digitalis must be used with caution as it is cumulative, and even when increasing cardiac muscular contractility it is a question whether it is entirely without drawbacks to cause a heart with degenerated muscular fibre to contract too vigorously.

**INDIGESTIBILITY OF OYSTERS.**—Dr. T. W. Jones, at the Ohio Med. Soc., reported (*Col. Med. Jnl.*) the case of a boy five years of age, who on the 16th of November, ate a large quantity of fresh oysters, and immediately afterwards a quantity of stewed oysters. He then went to bed with the stomach ache. Three weeks afterwards the doctor was sent for and shown a chamber containing an enormous faecal mass, which the child had passed as the result of a purge administered by the mother the evening previous, and in this mass were at least two dozen raw oysters, fresh in appearance and entire and only a trifle darker than when eaten. The family lived on a farm, and there was no question that these oysters had lain undigested in the alimentary canal for three weeks.

**TRUE AND FALSE ANGINA PECTORIS.**—M. Huchard says that the false form may be due to nervous reflex or toxic changes, and generally ends in recovery; while the true form is caused by ischæmia of the cardiac muscle. In most cases the coronary arteries are found diseased or their opening in the aorta is narrowed by chronic endarteritis; lesions of the cardiac nerves are not frequent. He thinks true angina pectoris may end in recovery, but much more rarely than the false form. For the treatment he recommends nitrite of amyl, which acts more rapidly than injections of morphia, nitro-glycerine and nitrite of sodium. He also strongly advises the iodide of sodium given at a dose of one to two grains daily for several months.—*Brit. Med. Jnl.*

**TWO SIGNS OF TRUE CONVALESCENCE IN ENTERIC FEVER.**—In a communication to the Clinical Society of Paris, Dr. Chauffard indicates as sure signs of true convalescence in enteric fever, the occurrence of multiple abscesses and of a critical diuresis. The abscesses have a rapid and insidious development, and when once opened they cease to secrete, their walls uniting in a day or two. The diuresis is sudden, and the quantity of urine passed is very large. Dr. Chauffard's observations extend over the past two years, and in no case has he seen a relapse where these signs presented themselves.—*The Analectic.*

**TWO POINTS IN CONNECTION WITH ALBUMINURIA OF BRIGHT'S DISEASE.**—Dr. William Roberts, in discussing a paper on albuminuria, said (*Brit. Med. Jnl.*), when albuminous urine was added, drop by drop to a large quantity of water, a milky trail followed each drop; and at last the whole fluid became opalescent. This opalescence disappeared on the addition of an acid or an alkali, and was probably due to the presence of globulin or paraglobulin. The second point was that albuminuria associated with hypertrophy of the left ventricle was usually permanent.

**HUMANE BLISTERING.**—Samuel Shelton, M.R.C.S., (*Brit. Med. Jnl.*) directs the surface requiring counter irritation to be well covered with annular blisters about the size of the human iris, cut from vesicating tissue with an ordinary gun punch, the centre being extracted with a punch of smaller size. He says that attached to the surface, and covered with cotton wool and a bandage, they require no further attention, and cause the very slightest discomfort.

**HEMILATERAL VARIOLOID.**—A curious case came under my observation some time ago. I was called to see a patient. I found that he had a bad case of small pox. I found in the house a boy of ten, who had never been vaccinated. I vaccinated him at once on both arms. This vaccination took on one arm, but not on the other. A few days afterwards the boy developed varioloid on the side on which the vaccination had not taken, and the disease was entirely confined to this side. Dr. Miller in *Rep. Md. Board Health.*

MODIFIED HELLER'S NITRIC ACID TEST.—H. C. Benning in *Phil. Med. Times*, modifies Heller's test for albumen, by boiling the nitric acid, and while boiling hot overlays it with the urine. The hot acid prevents the formation of the zone of acid urates.

CURE FOR CRAMPS.—A writer in the *Brit. Med. Jnl.* declares that the elevation of the head of the bed, by placing under each leg a block of the thickness of two bricks, is an effective remedy for cramps.

DR. PETERSON, of Kiel, considers oxide of zinc a good substitute for iodoform. It is cheaper, and is not poisonous.

### Surgery

#### THE TREATMENT OF CARBUNCLE BY COMPRESSION.

BY JOHN ASHURST, JR., M.D.

This man has been already before some of my ward classes; but, as there are many present to-day who do not meet me in the wards, I am glad to have the opportunity of bringing him before you. He presents one of the most instructive cases which we have had in the hospital this winter.

This patient was admitted to the ward on Wednesday of last week, being ten days ago, with a very large carbuncle of three weeks' duration. It began as a pimple, and gradually increased in size. This is the usual history of a carbuncle: first, the presence of a pimple, which soon develops a central vesicle, and then, either with or without irritation, such as scratching or pricking with a pin, begins to spread, the carbuncle in a week or ten days attaining its maximum size, seldom more than four or five inches in diameter. Yesterday a week ago, measuring this carbuncle, we found its dimensions to be nine inches by eight, independently of the large amount of indurated tissue around the livid mass itself. The dimensions of the carbuncle, including this indurated tissue, were at least eleven by ten inches, and it was fully three inches in depth.

A carbuncle is in reality nothing but a large boil; there is no absolute distinction between a furuncle and a carbuncle. This carbuncle is now smaller than it was when the patient came to the hospital, and

it is subsiding every day, though up to the time of the patient's admission it had been steadily increasing in size.

There are some peculiarities about the ulceration of a carbuncle which have not been understood until quite recently. It had long been observed that carbuncles were apt to ulcerate at numerous distinct points, giving the surface a sieve-like or cribriform appearance; but the anatomical explanation of this condition has only been furnished within a few years by an American surgeon, Dr. Collins Warren, of Boston. By microscopical examination of the skin of the back, where carbuncles usually occur, Dr. Warren has found little processes or tubes of fat connecting the deeper tissues with the surface; he has named these tubes the fatty columns, or *columnæ adiposæ*; and it is along these columns that the pus of the carbuncle, which originates as a phlegmon of the deep cellular tissue, begins to make its way to the surface. In this case there are as yet but two openings, which lie close together and probably will soon coalesce. A slough—what is popularly called the *core*—is beginning to protrude from one of these openings: it is a slough of the deep cellular tissue.

Carbuncle, while a very painful and annoying affection, is usually not a very dangerous one when properly treated. Death does, however, occasionally follow, and I have recently seen the statistics published by a German surgeon, who treated eleven cases of carbuncle by incision, six of these proving fatal by pyæmia. I have myself seen no death from carbuncle, nor do I recall any in the practice of other surgeons, unless in cases where there was some grave constitutional complication.

Carbuncle in one part of the body, the face, is considered particularly dangerous. It is said that but one case in nine gets well; but my own observation would lead me to think this an exaggerated estimate. This is a comparatively rare form of the disease, but I have seen two or three cases of facial carbuncle, all of which have ended favourably; it is true, however, that none of them were very severe. Death in facial carbuncle results from transference of the inflammation to the sinuses of the dura mater, or from pyæmia. But in ordinary carbuncle, unless the patient has Bright's disease, or diabetes (an affection which

predisposes to carbuncle), or unless the inflamed mass is so situated as to endanger internal organs,—peritonitis may follow an abdominal carbuncle,—death will seldom ensue, except as a result of injudicious treatment.

The old-fashioned treatment, which in my student-days we were taught should be used in every case, was to make an incision the entire length and depth of the carbuncle, this incision being crossed by another at right angles to it, and extending the entire breadth and depth. Had this mode of treatment been practised in the case before you, we should have had two incisions, one eleven inches long by three deep, and the other of the same depth and ten inches in length. You can see what an enormous wound would have been made, and how much blood would have necessarily been lost. Death even may occur from hemorrhage, for there is a recorded case in which a surgeon made the regulation-incisions in the afternoon and directed the nurse to apply a poultice, saying that he would see the patient in the morning. Next morning he went to see his patient, and found that he had died from hæmorrhage during the night. Then, besides this risk from bleeding, incisions increase the risk of absorption of poisonous matter, as they leave a very large raw surface. Another, though less serious, objection is that the resulting wound is a very large one, and that the time required for healing is correspondingly prolonged. In order to avoid hæmorrhage, some surgeons practice subcutaneous incision; but this is an uncertain operation and presents no particular advantage.

Of course, the treatment by incision has something to be said in its favour. No course of treatment could have been in general use for so many years without being of some value. It somewhat diminishes the pain of the carbuncle, and sometimes seems to prevent its spread, but it is not always certain even that it will do this. The disadvantages of incision I consider much greater than its advantages.

There is another mode of treatment which is adopted either by itself or in connection with incision,—the use of caustics. They are either employed to cause central sloughing or are applied as "caustic arrows," like the spokes of a wheel. The use of caustics in this way

was introduced by Maisonneuve for the removal of tumors, and Sir James Simpson recommended the injection of caustic solutions in a similar radiating manner. I can remember quite distinctly the case of an old man with carbuncle who was a patient in the Pennsylvania Hospital when I was a resident physician there. The usual crucial incisions had been made, causing great pain and free bleeding, and it was my duty every day to cauterise the wound with the solid stick of nitrate of silver; and I can remember how that old man used to fairly shiver with the pain at every dressing. He got well at last, but it was after many weeks of needless suffering.

The first case in which I used the pressure treatment, which I now invariably employ, was that of an old woman at the Episcopal Hospital, who had a large carbuncle, and who was so old and feeble that I thought it would be really dangerous to make incisions. Mr. O'Ferral, an Irish surgeon, was the first to recommend this mode of treatment: he applied compression by means of a plaster made to cover the whole mass of the carbuncle, and when suppuration began he cut a central opening for the escape of pus. I have preferred to use adhesive strips laid on concentrically, just as we use them in the treatment of swelled testicle.

We begin to apply the strips at the margin, and gradually bring them more and more inward, leaving a space at the centre to allow the slough to come out. We began treatment in this case last Wednesday a week: up to that time the carbuncle had been constantly increasing, but since then the progress, fortunately, has been the other way. The pain was immediately much relieved, so that the patient has now only an occasional darting pain, but nothing really to give him distress. The carbuncle is smaller, and is getting flatter. It now measures eight by seven and a half inches, and is not more than two and a half inches deep. The patient has not lost a drachm of blood since he came into the hospital. You can see that the pus and sloughs of cellular tissue are slowly discharging themselves, and there is so far no sign of any additional opening. We have every reason for thinking that this patient will convalesce without any further trouble. Over the centre of the carbuncle we are using a small poultice, which we

will change after a time for a dressing of resin cerate or zinc ointment, as may seem desirable.

There is another mode of treatment of which I have heard, but which I am happy to say I have never seen practised. Some surgeons have been so heroic as to excise the whole mass of the carbuncle; some surgeons, too, have excised gummatous tumours. The first can be made to disappear by simple compression, and the second will be absorbed under the use of iodide of potassium. To excise the one is as unjustifiable and as unnecessary as to excise the other.

In this case, on account of the mode of treatment which we have adopted, the ulcer left after the separation of the sloughs will be small, and the cure will be much more rapid than it would be if we had made incisions. I do not know of any instance in which the dicta of "authority" have come down to us with more injury than in the treatment of carbuncle by incision.—*Phil. Med. Times.*

SEVEN SURGICAL FOLLIES.—Dr. John B. Roberts, says in the *Polyclinic* that if you watch carefully any series of operations done by various surgeons you will see committed what he terms the ether folly, the incision folly, the sponge, the styptic, the suture, the adhesive plaster, and the dose folly. The ether folly is almost universal and consists in the expression of the belief that the patient cannot be etherised. The fault lies with the physician in not administering the ether properly. Give the ether without air, or with as little as possible, and no animal can resist it. The incision folly consists in making cramped cutaneous incisions. Use a keen edge and a free hand in making cutaneous operation wounds. The sponge folly is the use of sponges in the belief that they are clean. Napkins or towels are just as good and cleaner. Sponges are too expensive to be thrown away after each operation and are very difficult to be cleaned properly. Perfectly clean surgical sponges are the exception, clean household towels the rule. At the *Polyclinic* he uses Japanese paper napkins which cost from \$6.00 to \$7.50 per 1000, they are crumpled up into a ball used for mopping up the blood and are then thrown away. The styptic folly is the remnant of tradition. Styptics are dirty,

often fail, and always retard the healing of a wound, ligation with absorbable ligatures is better, torsion still better, and in most cases pressure will accomplish all that is required. The suture folly consists in clinging to the idea that silver wire is the only wire suitable for sutures. Iron wire is stronger and cheaper, and may be used finer and is more flexible. The adhesive plaster folly is of common occurrence. The strips of adhesive plaster placed between the sutures of an amputation stump, obstruct free drainage, become soiled, cause pain on removal, and do no good. If the flaps are made properly and the sutures correctly applied a light, well applied bandage is all that is required. "I believe that operative surgery will be greatly improved as a scientific entity, when sponges, styptics, silver wire, and adhesive plaster are discarded in the dressing of wounds. If you have these articles for this purpose in your offices, I pray you to throw them away. They are useless, worthless, and detrimental. We need a Leo and a Constantine to destroy these valueless relics of ancient surgical worship, as we need an Alexandrian fire to consume the thousands of worthless splints and instruments that are still described in surgical text-books to the confusion of the student and the damage of the community." The dose folly should perhaps be termed the small dose folly. Of what use is a sixteenth or an eighth of a grain of morphia to a man with severe pain? Give him a quarter of a grain or even a half, repeated if necessary and he will soon be comfortable and thankful. Perhaps he will also pay his bill. So with other medicines, give them in doses such that their effects will be produced promptly. Many physicians and surgeons fail to cure on account of insufficient dosage.

FARADISATION IN RINGWORM.—A. F. Samuels, in the *N. Y. Med. Jul.*, says that in an obstinate case of ringworm on the forearm he applied the Faradaic current, the positive pole at the end of the elbow, the flat electrode of the negative pole being passed repeatedly over the seat of disease. The intense itching ceased immediately, and a clear exudation like minute drops of sweat appeared on the surface. A second application, two days afterward left nothing of the ringworm but desquamated skin.

**DISLOCATION OF THE COMMON CAROTID ARTERY.**—Dr. F. Lange presented a patient, a woman forty-seven years of age, who had been troubled with a disagreeable feeling in her throat for about nine months, which she described as a perpetual desire to swallow. She had been treated with internal remedies and external applications, and called at his office about a week ago, when he examined the throat and discovered, what could be readily seen on the posterior wall of the pharynx on the right side at the lower edge of the arcus pharyngo-palatinus, a roundish pulsating tumour. Closer examination showed that it was the common carotid artery, which was dislocated and could be traced by laryngoscopic examination as far down as the arytenoid cartilage.

There were also hypertrophy of the left ventricle, a decided thickening of the coats of the other carotid artery, which was abnormally superficial, and some albumin in the urine. The patient said that about nine years before she had an attack of acute nephritis. The question was, whether the trouble depended upon the anatomical abnormality, and had always existed, or only since the trouble in her throat had been manifested.

On the left side the soft parts were slightly prominent, and were sunk in on the right side. Dr. Lange thought the prominence on the left side was due to the superficial position of the common carotid artery. Moreover, the entire larynx seemed to him to be abnormally movable, especially so as on the right side one could pass the fingers behind the thyroid cartilage and pull the artery out, dislocate it laterally, and push the larynx well over to the opposite or left side. He thought it probable that it was the common carotid and the beginning of the internal carotid which were dislocated. The artery seemed so movable beneath the mucous membrane of the pharynx that, by some pressure from the right side, it could be pushed almost as far as the middle line passing from there upward and to the right side in a curved line.—*N. Y. Med. Jnl.*

**CAUSES OF MOVABLE KIDNEY.**—Upon consideration of the position of the kidney, it being entirely behind the peritoneum, and securely held in position by the vessels and nerves entering the hilum, and by abun-

dant connective tissue holding it in direct contact with the posterior abdominal wall, it becomes obvious that very peculiar and unnatural influences must be in operation to effect its dislocation and constitute the movable kidney.

While not an uncommon condition at post-mortem examinations, it is apt to be overlooked, because of the kidney retaining its relative position. According to observation, the affection is markedly more frequent among women than among men, and before puberty is very rare. Senator has noted this lesion in one out of one hundred and forty adult females suffering from disease. As a cause of movable kidney, the commonly accepted condition, disappearance of the fat of the capsule, is inadequate. Senator considers the chief exciting causes, which specially explain the more frequent occurrence in females, to be as follows: Relaxation of the abdominal walls through repeated pregnancies; change of position in the organs of generation; tight lacing of the upper abdomen, which leads to dislocation of the liver, and to stretching of the hepatico-renal and duodeno-renal ligaments. The last also explains the fact that the right kidney is the one most frequently at fault, the greater length of the right renal artery, and the attachment of the colon, perhaps, having some share in the result.—*Maryland Med. Jnl.*

**BOILS.**—Dr. John Aulde, following the suggestions of Dr. Sidney Ringer, has met with most satisfactory results by adopting the following plan. The diet is to be regulated, and if constipation exists, a teaspoonful of magnesia sulph. in a glass of cold water should be taken every morning before breakfast.

**R.** Calci Sulphidi .....grs. iii;  
Sacch. Lactis .....grs. xxx.  
Misce bene et divide in chartulas No. xxx.  
Five powders daily at intervals, between meals.

By this method, beginning boils will be aborted, and those far enough advanced to threaten a siege of several weeks and successive crops will soften and heal in such short time that the patient will be surprised at the result. When they can be obtained, granules containing one tenth grain are to be preferred to the powders. The urine should be examined for sugar, as boils and diabetes often go together.—*Louis. Med. News.*

THE DOSIMETRIC EMPLOYMENT OF CHLOROFORM IN PRODUCING ANÆSTHESIA.—M. Paul Bert presented to the Société de Biologie the method employed by Dr. Pezraud, which consists in placing a very fine small compress over the nose and mouth of the patient, and dropping upon it with each respiration one drop of chloroform; at the end of a few minutes, if insensibility does not follow, two drops are given, and by this method complete insensibility is produced at the end of seven to ten minutes. During this time the pulse and respiration remain regular, and anæsthesia obtains in a progressive manner, with only the slowing of the pulse to indicate it; there is no agitation and no hyperæsthesia, even with alcoholics or nervous women. When anæsthesia has been produced, it is maintained by three or four drops of the chloroform every minute. By calculation, it takes in this way a mixture of ten to fourteen grammes of chloroform with 100 liters of air to produce the anæsthesia.—*Jnl. Am. Med. Ass.*

SURGICAL TEACHERS.—But because men are well known—probably through their writings—is no reason why they should be good teachers. As a rule, it does not follow. Prof. Lister, whom I saw operate several times, hardly explained his operations at all, while Mr. Wood, who operates in the same theatre, but is not near as well known, explains everything. Mr. Bryant, at Guy's, drills all who attend his clinics or operations thoroughly. Matthews Duncan is an excellent teacher, although he has a very broad Scotch accent that makes it hard to understand him at first. Still he is a very interesting lecturer, and sandwiches in a good deal of wit and fun in what might to some be a dry and uninteresting subject. He never performs any of the major operations, such as ovariectomy, himself—Mr. Willet, who is an excellent operator, doing it for him.—*G. H. S. in St. Louis Courier.*

POLYPI IN THE EAR TREATED WITH ALCOHOL.—Politzer is said to obtain good results in polypi of the ear by the instillation of a few drops of warm alcohol several times a day into the external meatus. The treatment extends from a fortnight to two months. The polypi gradually shrink and disappear.—*Phil. Med. Times.*

OSSEOUS REPRODUCTION EIGHT MONTHS AFTER RESECTION OF ELBOW.—M. Cauchois exhibited the specimens from a woman who in February had had the right elbow resected for osteo-arthritis. The following December the arm was amputated. The examination of the elbow showed the humeral extremity rounded in the form of a condyle and it presents at its external border, a small apophyseal protuberance which was bound by fibrous tissue to an anterior protuberance of the ulna evidently tending to the reproduction of the coronoid apophysis. The radial extremity is slightly rounded and presents nothing peculiar. But the extremity of the ulna forms behind, a normal olecranon protuberance less the beak of the olecranon. In front the bone supports a small apophysis which is directed outwards and upwards towards the small apophyseal protuberance above mentioned, on the external side of the humerus. It occupies the position of the coronoid apophysis, the type of which it tends to reproduce. There is no trace of cartilage nor of articular synovial cavity, in a word, no new articulation. The extremities of the three bones are bound together by cicatricial fibrous tissue which allows free movement. The resection comprised the entire articular extremity of the humerus.—*Jnl. de Méd. de Paris.*

IN rachitic children the bones yield to pressure whilst in a child of the same age and not suffering from rachitis the bones offer great resistance. Acting upon this principal M. Germain Sée has succeeded in straightening the lateral curvature, of the tibiæ of a rachitic child, by manual efforts only.

LOTION FOR CONTUSED WOUNDS.—D. C. Hewson, M.D., in *Med. News*, recommends the following: R. sodæ hyposulphitis  $\zeta$ iv. acidi carbolicæ cryst.  $\zeta$ ss, glycerinæ  $\zeta$ ij., aquæ Ci. sig. To be used as a lotion, and to keep a cloth saturated with the lotion continually applied to the part.

M. DIDAY, of Lyon, gives the following account of his method of instructing his patients: "I write my prescription and detail it *vis à voce* to the patient, who is then required to repeat it to me. I then give him the paper and make him read it. 'Now,' say I, 'repeat what you have just read.'"

## Midwifery.

THE OVARIES AND MENSTRUATION.—The relation of the ovaries to menstruation has been the subject of much discussion; the most discrepant views being advanced by the partisans of opposing camps; and still further difference has arisen as to the exact relation of ovulation, or the ripening of Graafian follicles, to menstruation. Because, in a few instances, women have menstruated after the removal of both ovaries, it has, on the one hand, been held that these organs cannot be essential to the function, while, on the other, it is alleged that their removal is commonly attended by its entire abrogation. Premising large qualifications, there is truth in both statements. Those who allege that menstruation may continue with its wonted regularity after the removal of the ovaries, do so on the evidence afforded by ovariectomies or oöphorectomies, wherein both ovaries have been removed without affecting the flow. Undoubtedly, such cases are on record; but I would beg your special attention to this important fact: that, while they are rare, they are, without exception, in mature or adult women, that is to say, in persons in whom the function has long been established, and whose bodies have been, and presumably therefore remain subject to its periodical impress. The ovaries are now often excised to arrest hæmorrhage from uterine fibromata, and for other maladies, with, it is alleged, abundant success. No cases are known in which the complete ablation of the ovaries in early life has been followed by menstruation; it is abundantly proved that the removal of the sexual glands in early life is attended by the absolute abrogation of the sexual characteristics of the sexes. The whole truth rests absolutely with neither side, though it predominates enormously in favour of those who hold that the ovaries exert an important influence over menstruation.

And with regard to the ovulation-theory: here, also, the conflicting views admit considerable reconciliation. The researches of Pouchet, and others, have demonstrated the intimate relations that ordinarily exist between ovulation and œstro-menstruation. Although this relation is in the normal state harmoniously synchronous, yet it has been shown that ovulation may oc-

cur without its accompaniment, menstruation. It is held, by those who affirm that menstruation is directly excited by the maturation of Graafian follicles, that it only occurs in association with the ripening of Graafian vesicles, just as happens at the time of œstration in the females of the lower animals; and they alleged that menstruation is the exact analogue or counterpart in the human female of œstration in the lower animals—a statement which is to a large extent, if not entirely, accurate.

In the human female, there can be no question that the menstrual function is largely associated with the maturation of Graafian follicles, and that women, like the lower creatures, are more apt for conception about the period of menstruation; but, as sexual aptitude is not confined in women solely to the period of heat, and intercourse may be indulged in at any time, it is obvious that a disturbing element is introduced, and that, under artificial conditions, ova may be matured through sexual stimulation, or follicles ruptured under sexual excitement, which, but for such intervention, would have remained quiescent or dormant until the next normal œstration.

Menstruation in women, in the ordinary normal undisturbed way, runs an even course with œstration in the lower females up to a certain point, but goes beyond it in that both the flow and ovulation may occur independently one of another. When the highest sexual organs (ovaries or testicles) are completely removed early in life, the characteristic sexual differences either do not appear, or are conspicuously modified; but, when their removal is deferred until these sexual differences have arisen, endured for some time, and have permanently left their mark upon the organism, the record of them, though perhaps not absolutely indelible, seems persistent in proportion as it has become established; and that may depend not alone upon its mere duration, but also upon the original intensity or inherent vigour of the sexual system.—*Brit. Med. Jnl.*

SACRACHE AND BACKACHE.—There is no more common, and, therefore, no more important symptom of uterine disease, and especially of disease of the neck of the womb, than sacrache. The pain is dull, or an ache rather than pain. It is situated at or near the base of the sacrum, and, re-

ferring to it, the patient puts her hand to the part. I say with emphasis, "at or near," and it is desirable to make this more definite. A pain below the middle of the sacrum is not at or near, and a pain above the middle of the lumbar spine is not "at or near." Such pains and aches do not point to the womb as the characteristic sacrache does; but the characteristic sacrache only points in that direction. It is not in itself nearly sufficient, nor even strong evidence of disease of the womb. Occurring in a virgin, it would not alone, unless very very severe and inveterate, lead you to make an actual examination of the womb.

Other back aches, that is, pains in other regions of the back, not the sacrache, may accompany uterine disease, but do not point to the womb, are not symptoms rationally held as indicating womb disease. Unfortunately women are at present so under the influence of bad medical instruction that they regard all pains in the back, from the occiput to the coccyx, as nearly sure indication of uterine mischief, and demanding uterine treatment.

The sacrache of womb disease may be constant, but generally it comes and goes. Frequently it is dispelled by lying, is felt on going to bed, and has disappeared before morning, and long standing makes it reach its highest pitch, then it is otherwise, that is, when the ache is worse in the morning before getting out of bed or is relieved by walking. Then it is certainly not uterine.

I have said that you must not regard all sacraches or other back aches as uterine. They are common in men and in women. A weakly woman who attends to all her pains, can do no standing or walking without back ache, and often it is a sacrache. Especially if she has a long back will she suffer in this way.

The pains liable to be confused with real sacrache are all in the lower back about the lumbar spine. It is only such that might mislead any rational physician. Regarding them, you will get some light from noticing the causes of the same pains in men. Now, I find that weakly men are liable to these aches, sacral or lumbar, on walking or standing, and in many they are produced by excessive venereal indulgence. *Maryland Med. Jnl.*

RUPTURE OF THE UTERUS.—Samuel D. Gilbert, M.D., reports (*N. Y. Med. Jnl.*) a case of rupture of the uterus in a multipara, æt. 34. Breech presentation; os not rigid; vagina cool and moist. On external examination the head was found to the left side of the abdomen, and it seemed to be just under the skin, the uterine walls were so thin; pains slight and infrequent. After some hours, with no progress, the membranes were ruptured; chloroform administered, and delivery proceeded with; the body was with difficulty extracted as far as the shoulders, when the os contracted like a vise around the neck of the child. After fifteen minutes, when the head emerged from the os there was a distinct and sharp tearing sound, and the patient instantly collapsed. The fundus contracted promptly, and on following up the funis, it led through a rent which extended through the cervix, and perhaps into the body of the uterus; the hand followed the funis into the abdominal cavity; found the placenta, and extracted it; a large amount of blood was lost. In two hours, with stimulants, ergot and heat, reaction followed. Tympanites, offensive discharge, and considerable fever ensued, and in a month complete recovery.

STUDIES ON COTTON BARK (RAD. GOSYPHII) AS A SUBSTITUTE FOR ERGOT.—Prochnick read a paper with the above title before the German Gynæcological Society.

He had experimented with cotton-root bark because he thinks it desirable to find a substitute for ergot. The action of the drug when employed during the last stages of the expulsive period is inferior to that of ergot, but it produces no tetanic contractions. When given during the lying-in, the effect was very satisfactory. But the author was particularly pleased with it in gynæcological cases, in hæmorrhages continuing after the removal of remnants of abortion. In myomata, the metrorrhagias often diminished as early as after two months, but usually after three, and a reduction in the size of the tumour could also be demonstrated. Infusions of the fresh drug produce the best results. The American fluid extract is likewise to be recommended. The drug is considerably cheaper than ergot. In reply to a question by Schatz, the author added that the agent can by no means fully supplant ergot.—*Maryland Med. Jnl.*

DEEP SUTURES IN HÆMORRHAGE FROM LACERATIONS.—So, if you have a post-partum hæmorrhage, and find the uterus firmly contracted, you can be sure that the blood does not come from the uterus, though you may not know where it is from, and sometimes in these cases it is from the vestibule. In these cases you can not take up the bleeding vessels one by one and tie them, but sometimes injections of cold water or applications of ice will check the bleeding. Some say you can use persulphate of iron here, but this sometimes will not stop the hæmorrhage, even after it has been in contact with the bleeding surface for an hour or two; but, as soon as you remove the cloth wet with it, the bleeding starts afresh. In such cases it is best to simply put in one or two deep sutures, extending around the two sides of the laceration, and bring the bleeding points together; this will stop the hæmorrhage at once, and with very little pain.—*N. Y. Med. Jnl.*

A LIVING CHILD AFTER CRANIOTOMY.—At the meeting of the Royal Society of Physicians, of Berlin, of the 18th inst., Dr. Breus exhibited a living child eighteen days old on whom craniotomy had been performed. The conjugate diameter of the mother was nine centimeters ( $3\frac{1}{2}$  in.) On extraction by the forceps the left frontal bone was fractured during its passage over the promontory. The child, born asphyxiated, quickly recovered, without any paralysis and without pyrexia. The mother also made a good recovery.—*Louisville Med. News.*

THERE is a large and comparatively compact body of the public who never miss an opportunity of decrying orthodox medicine. They are dissenters in religion, and radicals in politics. They hate meat and drink, are vegetarians and teetotallers. They speak of medicine as "allopathy," and have unbounded faith in globules. They detest Jenner's discovery of the value of vaccination, which they hold at once to be useless as a protective against smallpox, and the vehicle for communicating disease.—*J. Milner Fothergill in Phil. Med. Times.*

ARTIFICIAL OYSTERS according to the *L'Union Médicale* are coloured by copper, and cemented to the interior of old shells, and furnished to the Paris markets.

THE  
**Canadian Practitioner,**  
(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, APRIL, 1884.

A DOMINION HEALTH BUREAU.

During the past month health matters have been very active, sanitary legislation especially being in great demand. The time of the meeting of the Sanitary Convention at Ottawa, was chosen, whether wisely or otherwise, to coincide with the session of the Dominion Parliament. It is almost impossible to say at present whether the interest in sanitary matters was sufficiently aroused in the minds of the medical members of Parliament, as to induce them for a brief season to lay aside their political schemes, and reassume the garb of their exacting profession. Their names do not figure largely in the list of attendants at the Sanitary Convention. At a meeting held in the Railway Committee Room, House of Commons, on the Tuesday afternoon preceding the Convention, they however made a better showing. There were two Honourable Senators present, Dr. Almon, and Dr. Paquet. Amongst the members of the House were Drs. Bergin, Orton, Sproule, Hickey, Grandbois, Fortin, Landerkin, and Rinfret, and from the profession at large, Dr. J. A. Grant, Drs. Powell, Church, Horsey, Small, Playter, Robillard, Kelly, Cranston, Logan, Wilson, Corbett, and Hunter. The object of the meeting was to consider the question of the establishment of a Dominion Sanitary Bureau. Dr. Bergin was voted into the chair, and Dr. Playter requested to act as secretary. Dr. Playter submitted a

plan for such a Bureau, in which it was proposed to associate it with the Department of Agriculture, the Minister of Agriculture to be the Minister of Public Health, and to take cognisance of vital statistics, quarantine, and such other matters as came under the Federal jurisdiction. A deputy Minister was to be a medical man, appointed by the government to be *de facto* the principal sanitary officer of the Dominion. A sanitary committee to be permanently associated with the deputy Minister for counsel and advice in all matters relating to the Bureau; this committee to be appointed by government in such a way that they shall as far as possible be representative of the Provinces, and that two shall retire every year. The committee to have a salaried chairman, and secretary, medical men appointed by government. The latter to be a permanent officer. The committee to meet in Ottawa at intervals, local sanitary officers to be medical practitioners, to be appointed throughout the Dominion, their duties to consist in sending to Ottawa, monthly reports of the sanitary condition and of the nature and prevalence of epidemics in their district, \$2 to be paid for each such report. This plan, it is estimated would cost about \$10,000 or \$12,000 for the first year.

Such in brief is the plan of the proposed Bureau as presented by Dr. Playter. The opinion of the meeting appeared to be in favour of the plan and a resolution was unanimously carried stating the desirability of the establishment of a Dominion Health Bureau associated with one of the Departments of State at Ottawa. A committee composed of Drs. Paquet, Grant, Bergin, Church, Hickey, Orton, Larocque, and Playter, was afterwards appointed to wait upon the Government with the plan under consideration. The meeting then adjourned.

Positions will thus be afforded for three medical men with salaries of from \$2,000 to \$1,500 each. For we opine the Deputy Minister is not going to serve the govern-

ment for nothing, although in the plan no provision is made for his salary. These salaries together with the estimated 145 local sanitary officers, 12 reports at \$2 each, \$3,480, makes a sum total of \$8,980. Leaving a balance from the proposed \$10,000 of \$1,020 to pay the *per diem* allowance of the committee, and to cover the costs of issuing the monthly reports and the annual report.

We respectfully submit that the proposer of the plan has made a mistake, and underestimated the cost of the establishment and organization of the Bureau. It would have been better to have named a larger sum at once, the probabilities of obtaining it are doubtless as great as those of the lesser sum.

Again, the work of the local sanitary officers as proposed will most surely conflict with the duties and privileges of the Provincial Boards, and this is not to be recommended. In other respects the plan has its features of usefulness, and will meet with the approval of medical men who have given the subject thought. Laymen who have interested themselves in health matters, are also aware of the necessity of a central Sanitary Bureau to look after those matters pertaining to the public health, which come under the proposed cognisance of this Bureau. Sir Charles Tupper has stated that no legislative change will be made in the direction of the establishment of a Central Bureau without the concurrent request of all the Provinces. It remains then for the sanitarians of the Provinces to so arouse the interest of the people of their respective districts as to demand the establishment of the proposed change, by relinquishing certain of their Provincial privileges.

#### THE COUNCIL CURRICULUM.

The committee appointed to consider this question propose to recommend the following changes: (1) Natural Philosophy to be added to the subjects required at the

Matriculation examination, and the following percentages to be required in the various subjects; sixty per cent. in English Grammar, English Literature, Composition, Dictation, History, and Geography; forty per cent. in Arithmetic, Algebra, and Geometry; fifty per cent. in Natural Philosophy; thirty-three per cent. in Latin. (2) Graduates in Arts to take the full course of four years as prescribed for others. (3) Botany to be struck out of Primary examination. Pharmacy to be substituted for Therapeutics in Primary. Candidate to present certificate of proficiency in mounting microscopic specimens. (4) Therapeutics to be included in Final examination. Candidates must present certificates of attendance on six *post mortem* examinations and ability to draw up a report of the same, and certificates of reporting satisfactorily six cases each in Clinical Medicine and Clinical Surgery.

#### PHYSIOLOGY AT OXFORD.

At a Convocation held at Oxford, on February 5th, 1884, an organized opposition was made against a grant of £10,000 which was required for the erection of a laboratory, working and lecture rooms for Dr. Burdon Sanderson, the Waynflete Professor of Physiology. After a very stormy meeting, one of the antivivisectionists condemned the use of the new schools for the fooleries of a ball room, or the museum for the horrors of a torture chamber. The Dean of Christ Church spoke in favour of the decree and remonstrated strongly against the unfair tactics of the opposition. Dr. Acland showed the misleading nature of the statements contained in the circulars issued by the antivivisectionists which were undated and unsigned and the most emphasized of the sensational extracts in them were misstated and untrue. The 'placets' had it by 188 to 149 votes. On the last occasion, when the matter was brought before Convocation there was only a majority of three votes.

#### TORONTO SCHOOL OF MEDICINE MEDICAL SOCIETY.

This Society, under the Presidency of Dr. Graham, has been very prosperous during the past year. The regular fortnightly meetings have been very interesting in their character, and have been well attended. The library and reading room have been highly appreciated by the members. Over two hundred dollars is now being expended in books to add to the library.

The following are the officers appointed for the coming year:—President, Dr. Cameron; First Vice-president, Mr. Sutherland, Second Vice-president, Mr. Glassford; Corresponding Secretary, Mr. Ellis; Recording Secretary, Mr. Hooper; Curator, Mr. Mullock. Council—Messrs. Johnson, Krick, Beemer, Perfect and Pickard.

#### ONTARIO MEDICAL ASSOCIATION.

The next annual meeting of this Association will be held in Hamilton, on the 4th, and 5th of June. The previous meetings were held in Toronto, but last year it was decided to make a change, and Hamilton was chosen. It will be remembered by all who have watched the proceedings of this Society from its inception, that the profession of Hamilton have always taken a very active and lively interest in its welfare, and we are much pleased with the decision to hold the fourth regular meeting in that city. We hope the medical men of the Province and especially Toronto will attend in full force. Further particulars will be given hereafter.

TRINITY MEDICAL LITERARY AND SCIENTIFIC SOCIETY.—The last meeting of this Society took place on March 15th. The following officers were elected for 1884-85. President, Dr. C. Sheard; Vice-President, Mr. J. R. Logan; Sec-Treasurer, Mr. F. H. Brennan; Committee, Dr. Teskey, Mr. H. H. Hawley, G. J. Dickison, J. H. Hoover.

### HONOURABLE CONDUCT OF A TORONTO NEWSPAPER.

On the occasion of the recent invasion of Toronto by the notorious double Ks, the press was very extensively subsidized. One paper however refused, as it always has in connection with the same fellows, to take the shilling, considering it wrong to insert disreputable advertisements at any price. The paper referred to is the *Toronto World*, which by the way is the the cheapest, most independent, and most readable morning daily published in the Province.

### MEDICAL SCHOOL EXAMINATIONS.

The present is an anxious time for the medical student. The levities and frivolities (if any there were) of the early part of the session are forgotten in the presence of the dreaded examinations. To the student who is well prepared, these should cause no serious tremblings, and yet they are to a certain extent dreaded by one and all. We believe, however, that the students of the Toronto Schools have been unusually faithful and attentive to their work during the last session, and we hope the class lists will furnish abundant proof of this. To the students we have only to say, we wish you all success.

A LOST MEDICAL WORK.—The *British Medical Journal* says that the Obstetrical Society of London desire to obtain a copy or a transcript of Woolveridge's *Speculum Matricis*. This is the earliest original work on midwifery in the English language. The only copy known to exist was in the possession of Dr. Fordyce Barker. At the request of the Society he employed a man to copy it; the man vanished, taking the book with him, and died in Europe. It is feared that the book is irretrievably lost. Dr. Aveling, in a later number of the same journal, states that a copy of the work exists in the Radford Library of St. Mary's Hospital, Manchester.

### CANADA MEDICAL ASSOCIATION.

The next meeting of this Association will be held in Montreal on the 25th, 26th, and 27th of August next. The meeting of the British Association for the Advancement of Science will commence in the same city August 27th, and it is hoped that many Surgeons and Physicians connected with the latter Society will be present at our Medical Association meeting. We understand that Mr. Lawson Tait will be invited to read a paper on Abdominal Surgery.

### OUR PUBLIC BUILDINGS.

The condition of some of our public buildings in Toronto, in a sanitary point of view, is simply abominable. Our City Hall, Court House, and Parliament Buildings are certainly a disgrace to the City, County, and Province. It is hard to understand why such indifference should be manifested respecting the health of public officials.

TRINITY COLLEGE UNIVERSITY. — At a meeting of the corporation the subjects of matriculation in medicine were revised, and the dates of examination were fixed for the second Friday and Saturday in March and October. Examiners—Rev. A. H. Baldwin, M.A., and Rev. T. Kirkland, M.A. The primary examination in medicine of other Universities would be allowed in Trinity. The degree of M.D., C.M., to be obtained the same as the M.B. Additional lectures on Medical Jurisprudence and Sanitary Science for the degree of M.D., C.M.

THE JOHNS HOPKINS HOSPITAL will not be opened before October, 1886, a year later than was expected. During the past year \$211,000 has been expended upon it, and it is estimated that for its completion \$400,000, additional is required. The annual income available to the trustees is now only \$135,000, therefore it behoves them to be economical.

THE Provincial Legislature have during their recent session done some meritorious work in the passage of Acts relating to the Public Health. Notably in the Public Health Act whereby Local Boards are permitted to be established and powers conferred upon them to enforce the performance of their suggestions. The Municipal Amendment Act deals largely with the sanitary questions of drainage, etc. Other Acts with respect to the suppression and prevention of Contagious Diseases in Cattle were also passed. Want of space prevents a more extended notice of these Acts.

HYDROSALPINX AND PYOSALPINX. — Mr. Lawson Tait, writes to the *Brit. Med. Jnl.* that having carefully preserved the uterine appendages in all his cases he has accumulated a large mass of material useless to himself but which may be of use to others. Having supplied the large museums in England with as many specimens as they want, he expresses his willingness to supply other museums on application.

MR. W. D. SPANTON, in an address commenting on the work done by the Hanley Sick Nursing Establishment said, that a large class of people knew nothing of the most ordinary management of the sick; and he suggested that in place of the ridiculous headwork that some of the girls at school had to go through, they should be taught the rudiments of helpful attendance at the bedside of the sick.

A SANITARY Convention is to be held at Hillsdale, Mich., on April 17th and 18th, 1884, under the auspices of the State Board of Health. A number of interesting and important subjects are to be treated of in papers and by discussion.

#### CHARLES HENRY LAVELL, M.D.

Died at Kingston, on the morning of Tuesday, the 26th day of February, Charles Henry Lavell, M.D., Professor of Practical Anatomy and Ophthalmic and Aural Surgery, in the Royal College of Physicians and Surgeons, Kingston, eldest son of M. Lavell, M.D., in the thirtieth year of his age.

## Meetings of Medical Societies.

### TORONTO MEDICAL SOCIETY.

Feb. 28th, 1884.

The President took the chair at 8.25. *after 30*  
~~The minutes were read and confirmed.~~

Dr. J. F. Ross read ~~an interesting~~ paper upon "The Wintering of Invalids. When, Where, and How to Go: with Notes by the Wayside." Dr. Ross mentioned the want of definite information concerning the health resorts of this country, the ignorance of the special inducements of certain places and their equally special drawbacks. His remarks were based largely upon personal observation. In regard to the time when one should proceed to those places, in climates such as ours—the winter months were those in which the patient required to be absent. At the very commencement of pithistical signs in the chest, before the disease had had a chance of making headway, if the patient was pecuniarily able to go, he should start at once and remain away the entire winter. Those suffering from chronic articular rheumatism and chronic diseases of the bronchi and kidneys are likewise benefited in many cases permanently by an early fitting and by not returning until spring had well advanced. Where to go was a question of very great moment. The well-known health resorts of Italy and France are too far to be reached by a large class of patients. Florida was for many too wet; Texas subject to too many sudden changes of temperature; Southern California possessed most of the requisites of an ideal health resort. Patients should endeavour to go where the society and refinement and amusements to which they have been accustomed, are coincident with the proper climatic conditions. Santa Barbara, on the coast of California, presented most of the conditions sought for by the unfortunates. It was situated on a southern slope towards the sea—protected on the north and east from the cold and dry winds from the adjacent desert, with a satisfactory temperature and rain chart, and all the benefits of a refined and wealthy society, and was within easy reach of other resorts, as the Ojai Valley, Los Angeles, S. Gabriel Valley, etc. The patient should leave home prepared for a protracted sojourn.

The paper was illustrated by maps; dia-

grams, and some very interesting photographs of Santa Barbara.

Dr. Carson asked if there was any place in America which would be an equivalent of Davos Platz and San Moritz. He had heard Colorado extolled.

Dr. Aikins wished to know what class of cases would be benefited by a residence in high altitudes.

Dr. Nevitt said that Dr. Reed, of Colorado, had written upon the subject of high altitudes in the treatment of phthisis, and advocated Colorado Springs for certain cases. Dr. Theodore Williams had found those cases benefited most by the high altitude whose disease was limited, the subjects of hæmorrhage, but not those subject to pyrexia. The chest measurements were generally increased and the area of dulness diminished, emphysema was usually developed, possibly by the greater respiratory exertion induced by the rarefied air.

Dr. Smith, in the absence of Dr. Spencer, presented a patient. He was a young man from the lumbering districts—no specific history obtained. He had numerous and deep mucous patches in the mouth; the tongue was fissured; there was glandular enlargement; there had been no rash; the hair had been falling out. He had been in the habit of smoking the pipes of his indiscriminate companions.

Dr. Ross presented the stomach of Mrs. D., with the following history:—Mrs. D., æt. 66. Father died suddenly, æt. 77; mother died of paralysis, æt. 86. Two of her sisters are dead, one æt. 7 and one at birth; one sister and four brothers alive and well. Married young; husband died seven months afterwards; had one miscarriage at five months; three years ago had typhoid fever. Until three years ago was apparently well. Twelve months ago was ill with so-called remittent fever. In July, 1883, had a severe chill, pain in bowels, diarrhœa and tympanites, vomiting, anorexia, emaciation; skin became yellowish in colour. Never noticed any abdominal lump until lately. The tongue is red; appetite poor; takes beef tea and oysters without pain or discomfort; no vomiting for several days; some diarrhœa present, passing mucous shreds. Pulse 116; right foot swollen; left foot never swelled; respiration 36; no cough. The *post mortem* disclosed a cancerous enlargement of the lower and posterior

portion of the stomach adherent in part to the pancreas; the right kidney was cystic.

Dr. Cameron exhibited a placenta illustrating fatty degeneration, and giving rise to premature delivery. — Mrs. G., æt. 28; Irish; nine months married; menstruated last on June 5th; a show in July after a long walk, and again in August; was sent for on February 5th. The night previous she had been taken with pains in the back and stomach, which had since continued, and she thought she was about to be delivered of her first child. She had not expected to be ill for another month. On examination *per vaginam*, a large, broad, hard swelling was felt bulging the uterine wall behind the bladder; the cervix was high up posteriorly, dangling loosely in the vagina and sufficiently patent to admit the index finger, and within a flaccid bag of waters was palpable. The presentation could not be ascertained. By external manipulation it was made out to be transverse, the breech in the right iliac fossa, the head in the left, the back towards the mother's abdomen. The fetal heart beats could not be detected, and the fœtus was small. Attempts at rectification by external manipulation were made, and the case left. Three hours later the pains had continued vigorously, os well dilated, head presenting, the bones of the skull being exceedingly mobile. The anterior lip was resistant, and between the pains it was slipped up over the occiput. Delivery was accomplished within an hour of a dead fœtus, the skin universally macerated and desquamating. The nails were pretty well formed. Pressure was at once made upon the fundus, and on detachment of the child so little cord was present that it occurred to me that it must be coiled up in the uterus, and its descent perhaps prevented by the engagement of the edge of the placenta in the cervix. Accordingly slight traction was made, it was felt to slip; and gentle traction being again made the cord came away entire. It proved to be fourteen inches long. Two fingers were passed up into the uterus and grasped the edge of the placenta, which after some pretty strong pains and firm pressure, came away. It was very small and presented here and there numerous patches, yellow in colour, hard and resistant to touch, and varying in size from a pea to an almond in the shell. There had been no history of syphilis. Microscopical examination showed

fatty degeneration with inflammatory infiltration and organization in parts.

Dr. Macdonald exhibited a placenta.—Mrs. A., æt. 22, primipara, menstruated last in September; morning sickness was very troublesome. In December choreic symptoms set in, affecting the right upper extremity especially; but extending to the right leg and foot. The chorea was treated with liq. arsenicalis and oxalate of cerium in two grain doses with some relief. About four weeks ago the foetal movements ceased to be felt, and afterwards the chorea disappeared. After a very rough drive pains set in, and there was a show, and one week after delivery took place. Six weeks before delivery she lessened in size. The placenta was small, hardened, and degenerated in spots. There was very little tissue left to carry on the foetal nutrition.

Dr. Cameron considered the spots to be hæmorrhagic.

Dr. Carson thought the oxalate of cerium in the doses given by Dr. Macdonald would possess little power ~~for good or ill~~. He had been in the habit of administering it in ten grain doses.

Dr. Graham communicated the history of M. H., æt. ten and a-half: Light hair and complexion. Two months ago noticed dizziness of the head; she then complained of being tired. About ten days ago the amount of urine passed was found to be increased and to have a peculiar odour. She has to rise at night to micturate; has been losing flesh. At school she was as bright as children usually are and her progress had been good. She has had no severe illness. The quantity of urine passed in twenty-four hours amounted to five pints.

*Family History.*—There are two children living, two dead; one æt. seven, died last autumn of diabetes. He had been failing for some weeks. Six weeks before death treatment was begun. He was in bed only four days before death.

The other child died of cholera infantum after twelve hours' illness.

Of the two children living one is the patient and the other a boy eighteen months of age.

There was as far as known no diabetes on either side of the family. Two of the father's brothers died from inflammation of the lungs, one from accident. One sister died of cancer, æt. 34; another of womb trouble, æt. 35-38; another of some affection of the liver.

The patient, appears dull and heavy; pale; bowels constipated; frequent thirst; appetite fair; temperature 99°; pulse 96°. The mouth frequently becomes dark red in colour.

It was not unusual that some members of a family should suffer without a family history of the disease. The father appeared to be of a nervous disposition.

Dr. Ross mentioned a case where two members of an otherwise healthy family suffered from diabetes. They were begotten while the father was drinking heavily.

Dr. Graham related the history of W. L., æt. 45: Hotel keeper for five years. Seven years ago he gave up hotel life and worked hard on his farm; never had ague; was very ill with measles at twenty years of age. Six years ago he had a severe illness. It began by his feeling sleepy, dull and weak. No appetite; nausea; took to his bed; jaundice set in and remained during his illness, a period of three months. He had a burning sensation in the soles of his feet. Before the jaundice set in he was very pale. He gradually recovered strength and remained fairly well until last March. He then began to feel the same train of symptoms: sleepiness, dullness, weakness, pallor; no jaundice. He took to bed on April 25th, and remained there until the latter part of August. He was unable to retain food, much emaciated, constipation very troublesome; at one time three weeks intervened without a passage from the bowels. His temperature was at or over 102° for weeks. During the latter part of his illness, he took a fancy for buttermilk which he retained on his stomach. Recovery slowly followed. He is now for the third time experiencing a recurrence of the same set of symptoms.

(A diagnosis of pernicious anæmia was suggested.)

Dr. Ross mentioned a case of a lady from Chatham whom he had lately seen with somewhat similar symptoms. She had had a rigor with high temperature, diarrhoea and vomiting; for weeks the only food retained was peptonized milk. The spleen was tender but not enlarged. She went home improved. He considered a relapse almost certain.

Dr. Cameron suggested the likelihood of malaria being the cause of her trouble, and a removal from the malarious Chatham district as likely to be of benefit to her.

Dr. Carson related a case of hæmatemesis which he had treated without styptics. Noticing that she had the pulse of high arterial tension, he had given her bromide of potash to dilate the capillaries, and gray powder to act on the bowels. On a second occasion nitrite of amyl proved equally efficacious in relieving her.

### SANITARY CONVENTION AT OTTAWA.

This Convention met in the City Hall at 11 a.m., March 11th. Dr. Sweetland, of Ottawa, in the chair, welcomed the gentlemen who had come to hold their annual meeting in Ottawa. The object of the Association was to disseminate sanitary knowledge amongst the mass of the people. He hoped the ladies would also attend, as they were so largely interested in sanitary reforms.

His Worship, the Mayor of Ottawa, welcomed the delegates, hoping the city would reap much benefit from the meeting.

Amongst those present were Drs. Oldright, Covernton, Cassidy, Canniff and Bryce, of Toronto; Mr. Boxer, Montreal; Drs. Hill, Robillard, S. Wright, Baptie, Playter, and Henderson, of Ottawa; Landerkin, M.P., and Rae, of Oshawa; M. Guerin, C.E., and others.

Dr. Oldright read an introductory address, in which he pointed out the importance of Hygiene, and how frequently it was overlooked. Sanitary reforms had effected a very great saving of life. Nearly one and a half lives per 1,000 had been saved yearly by means of the reforms introduced since 1875. Applied to Ontario this would mean a yearly saving of 2,800 lives. The institution of local boards of health, with power to carry out sanitary reforms, were responsible for this good. Doubtless, if in Ontario we could have such local boards, a very great proportion of the deaths from contagious diseases and from consumption could be prevented. The time was approaching when the Dominion would require a sanitary board. The Dominion Government alone being able to deal with the importation of disease by immigrants, the adulteration of food, prevention of loss of life in factories, and quarantine and vital statistics. These matters would furnish sufficient work to occupy the time and attention of a Dominion Board and prevent any fear of interference with Provincial

Boards. There was also much that could be done conjointly by the Dominion and Provincial Boards. The Provincial Board of Health had accomplished a vast deal of work since it was organized, though much remained to be done. An effort was being made to establish local boards throughout the Province in order to carry out sanitary suggestions that may be made.

Dr. Covernton said that in the last ten years the death rate in Great Britain was diminished by 300,000 as compared with the rate of the previous decade. He instanced the death rate in the hospitals of the Crimea with that of the hospitals during the American War—seventy-five per cent. of the French soldiers dying in the former, while in the latter only thirty-four per cent. died. He said that he regarded the accumulation of filth as the gunpowder and the disease germ as the spark—when they are brought together there is necessarily an explosion.

Dr. Robillard expressed his pleasure at seeing the Convention in Ottawa. He hoped much good would result from the Convention. He knew of many cases of disease caused by sewer gas escaping into houses.

Mr. Boxer said that last year thirty-one per cent. of the deaths in Montreal were from zymotic diseases, and in almost every case he had investigated the drains had been found defective.

At the afternoon session Dr. Canniff read a paper on the "Sanitary Education of the Masses."

Dr. Baptie delivered an address illustrated by numerous diagrams, on the ventilation of private dwellings.

Dr. Covernton read a paper on "The Abuse of Alcohol." He was not opposed to the moderate use of good wine. The principal beverage of the French peasantry was a light claret, and drunkenness existed among them to a very slight degree. He considered that the want of food led to the abuse of alcoholic stimulants quite as much as drunkenness conduced to poverty, and the drunkard in many cases was entitled to pity and assistance.

Mr. Woods, M.A., read a paper on "School Hygiene;" Dr. Bryce on "Zymotic Diseases;" Mr. Boxer, C.E., of Montreal, on "Hidden Causes of Disease Exposed;" and Dr. Roger, on "Prevention Better than Cure, or Ventilation vs. Quarantine."

Dr. Playter read a paper on "Diet in Relation to Disease," in which he attributed many evils to an over-indulgence in animal foods. He recommended cider as a beverage and saline drinks.

Mr. T. Guerin, on "Sewage," advocated no openings into the sewers on the streets, and that all pipes leading from the houses should be sufficiently trapped.

After the morning's meeting of the Sanitary Convention, a meeting of the medical men attending it, and some members of Parliament, held a meeting to advocate the establishment of a Dominion Sanitary Bureau. After some discussion the matter was postponed until after the next meeting of the Dominion Medical Association.

#### PROVINCIAL BOARD OF HEALTH.

Wednesday, February 6th, 1884.

First Regular Meeting for 1884.

The Board met at 2 p.m. The President in the chair and the following members being present:—Drs. Covernton, Cassidy, Rae, Yeomans, and Prof. Galbraith.

The minutes of last meeting were read and confirmed.

Correspondence and routine business ensued when the Board went into committee to consider the Report of the Legislative Committee.

February 7th.—The Board met at 10 a.m.

A communication was read from the Minister of Education in reference to the preparation of a work on School Hygiene. Dr. Oldright, Covernton, Cassidy, Yeomans, and Rae, were appointed a special committee to prepare the work indicated.

February 8th.—At this meeting of the Board a motion was carried appropriating a sum not to exceed fifty dollars for the purpose of a course of lectures upon Sanitary Subjects in connection with the Canadian Institute, provided that the matter meets with the approval of the Canadian Institute.

The expenses in connection with the publication of the weekly health Bulletin was next taken into consideration, and the Publication Committee requested to devise means to lessen these expenses.

The proposed bill from the Expropriation Association was then read by Dr. Oldright. The matter was referred for report to a special committee composed of the Committees on Sewage Ventilation, and on Contagious Diseases. The meeting then adjourned.

#### Book Notices.

*Winnipeg Public Vaccination Notice.* W. J. Wilson, M.D., Public Vaccinator.

*Peroxide of Hydrogen in Diphtheria,* by R. J. Nunn, M.D., Savannah, Ga.

*Report of the Medical Officer of Health for the City of Toronto,* January, 1884.

*Annual Announcement of Cooper Medical College,* San Francisco. Session 1884.

*Estudios Clinicos de Neuropatologia,* por José Armangué y Taset, Barcelona, 1884.

*Annual Report of the Presbyterian Eye, Ear and Throat Charity Hospital,* 1883, Baltimore, Md.

*Announcement of the Baltimore Polyclinic and Post-Graduate Medical School.* Session 1884. Baltimore, Md.

*Medical Symbolism,* by T. S. Sozinsky, M.D., of Philadelphia. (Reprint from *Medical and Surgical Reporter*.)

*Weekly Health Bulletins* for February, 1884. Provincial Board of Health. P. H. Bryce, M.A., M.D., Sec.

*New York State Medical Association.* Minutes of a convention for organization, Albany, N.Y., Feb., 1884.

*Annual Address before the American Academy of Medicine, at New York, Oct. 10, 1883,* by Henry O. Marcy, A.M., M.D., President.

*The Opium Psycho-Neurosis—Chronic Meconism or Papaverism,* by C. H. Hughes, M.D., St. Louis. (Reprint from *Alienist and Neurologist*.)

*Borderland Psychiatric Records—Prodromal Symptoms of Psychological Impairment,* by C. H. Hughes, M.D., St. Louis. (Reprint from the *Alienist and Neurologist*.)

*Is Extirpation of the Cancerous Uterus a Justifiable Operation?* By A. Reeves Jackson, A.M., M.D. (Reprint from Vol. VIII., *Gynecological Transactions*, 1883.)

*A Report on Cerebro-Spinal Pathology,* by Daniel Clark, M.D., Medical Superintendent Asylum for Insane, Toronto. (Reprint from the *American Journal of Insanity*.)

*Introductory Address to the Course of Clinical Lectures at the Hospital for Women, London.* Session 1883-4, by Protheroe Smith, M.D. London: J. & A. Churchill.

*Proceedings and Addresses at a Sanitary Convention, held at Pontiac, Mich., Jan. 31, and Feb. 1, 1883, and at Muskegon, Mich.,*

Aug. 23 and 24, 1883. (Supplement to Report of Mich. State Board of Health for 1883. Nos. 200 and 198.)

*Hydriodic Acid, and Dr. Churchill's Method of Treating Phthisis by Hypophosphates.* Pamphlet by Robt. W. Gardner, Pharmaceutical Chemist, 153 William St., New York.

*Weekly Meteorological and Health Reports for the State of Michigan, and Monthly Mortuary Statistics for the City of Lansing,* by H. B. Baker, M.D., Secretary State Board of Health.

*Our Water Supply. Suggestions as to the Water we Drink, and Where to Get it From.* (Read before the Manitoba Historical and Scientific Society, Winnipeg, by Dr. Agnew, 1884.)

*Hysterical Convulsions (Reflex), Perineorrhaphy and Trachelorrhaphy.* Report of Case, Recovery, by Thos. H. Hawkins, M.D., Denver. (Reprint from the *Denver Medical Times*.)

*Health and Home.* A Journal of Sanitary Science and Home Hygiene and the Official Organ of the Canadian Sanitary Association. Vol. I., No. I. Fred. N. Boxer, Civil and Sanitary Engineer, Manager and Editor, Montreal.

*A Treatise on Pharmacy,* designed as a Text-book for the Student and as a Guide for the Physician and Pharmacist, by Edward Parrish. Fifth edition, enlarged and thoroughly revised by Thos. S. Wiegand. Philadelphia: Henry C. Lea's Son & Co., 1884.

This old and valuable work in its fifth edition, is fully brought up to date. Its many excellencies are undiminished. The preparations of the New U.S. Pharmacopœia have been introduced, and the chemistry made to conform with the requirements of the chemical science of to-day. We cordially recommend the book to those who may require to compound or manufacture, or dispense their medicines, feeling sure, from a lively recollection of the comfort and assistance personally received from an older edition, that the present work will render those in need of it a similar amount of satisfaction.

*A Manual of Obstetrics,* by A. F. A. King, M.D. Second Edition. Phil.: Henry C. Lea's Son & Co., 1884.

A convenient little book, going over the

outlines of Obstetric Science in a sketchy manner, confessedly a compilation, but nevertheless, a good one. The author never uses chloroform in obstetric practice, preferring the safer agents, ether and chloral. Of chloral, he leaves one to infer only, that it does not succeed sometimes in accomplishing the end aimed at. In our experience it has frequently been of no apparent service. He regards Puerperal Fever as Septic Fever, which may be auto- or heterogenetic. The concluding chapter takes up and gives a good resumé of the Jurisprudence of Midwifery.

For those who have an unfortunate predilection for small manuals we can recommend this work as being more than usually free from the ordinary drawbacks of that class of books.

*The International Encyclopædia of Surgery.* Edited by John Ashhurst, jr., M.D. In six volumes. Volume IV. New York: Wm. Wood & Co.

Of the seven contributors to this volume, three are English, three American, and one Canadian. The first article, on Fractures, by Dr. John H. Packard, of Philadelphia, is very complete in every respect. Mr. Barwell, of Charing-Cross Hospital, London, writes the second article on Diseases of the Joints. This surgeon is so well known, even in this country, in connection with this subject, that a valuable treatise would naturally be expected. Such expectations will certainly be realized in its perusal. Dr. Ashhurst's article on Excisions and Resections is perhaps rather brief, but is certainly a most excellent one. The directions given in the different operations are very plain, while concise, and are well illustrated. Dr. Fenwick, of Montreal, in his article on Excision of the Knee Joint, describes his own method of performing that operation.

Mr. Butlin, of St. Bartholomew's Hospital, London, writes on Tumours; Mr. Treves, of the London Hospital, on Malformations and Diseases of the Spine; and Dr. Liddell, of Bellevue Hospital, New York, on Injuries of the Back, including those of the Spinal Column, Spinal Membranes, and Spinal Cord. We are pleased to be able to say that these articles admit of no adverse criticism.

*A Manual of Practical Hygiene,* by Edmund A. Parkes, M.D., F.R.S. Edited by F.

S. B. François de Chaumont, M.D., F. R.S. Sixth edition with an appendix, giving the American practice in matters relating to Hygiene, prepared by and under the supervision of Frederick N. Owen, Civil and Sanitary Engineer. Vol. II. New York: Wm. Wood & Co., 1883.

This is the November number of Woods Library. Beginning with the continuation of Book I. of Parkes' Hygiene, on Habitations, the subject matter is that of the original work. At page 391 the American Appendix is reached. It was with considerable interest, and some degree of curiosity that we turned to this portion of the work. And as we turn over the pages the conviction grows stronger that the American practice in matters relating to Hygiene, does not differ in any marked degree, or in any essential points from the practice of other nations and peoples similarly situated. An introduction by Mr. Owen, gives a short account of the rise and progress of Sanitary matters in the United States, and then follows a lengthy paper on Water, by Elwyn Waller, of New York; a paper by N. L. Britton, Ph.D., on American Soils; Climatology by J. G. Richardson, M.D.; Ventilation and Warming by D. F. Lincoln, M.D.; Removal of House Waste by Edward S. Philbrick, M.A., S.C.E.; Food Adulteration by E. G. Love, Ph.D.; Disinfection and Deodorization and Vital Statistics by Roger S. Tracy, M.D., and the whole concludes with some Hints to Sanitary Inspectors by Mr. Owen.

The Essays of the American Supplement are all excellent articles, some of them short but to the point.

*The Field of Disease: a Book of Preventive Medicine*, by Benjamin Ward Richardson, M.D., LL.D., F.R.S., 1884. Philadelphia: Henry C. Lea's Son & Co.

The American publishers deserve commendation for the efficient manner in which they have reproduced Dr. Richardson's work and issued it to the American Profession. Let us hope that by their avowed purpose of laying it before the Profession, they do not intend to exclude it from the more numerous class of readers to whose especial needs the author has catered in so eminent a manner. That the subject matter is put clearly, forcibly, and pleasantly, goes without saying. It is a philosophical classifica-

tion of Diseases, of their causes and origins, and of their preventions. The science of Preventive Medicine is the science of the medicine of the future. No physician can even now afford to be ignorant of the causes of disease so far as they are known, and the deeper the knowledge of the cause the more liability there is of acquiring the knowledge of the best means of preventing the operation of the malific cause.

The work is divided into three books, with a short introduction to each, upon Diseases, Acquired Diseases, and a Practical Summary of the Origin, Causes, and Preventions of Diseases.

Our Legislators at Toronto and at Ottawa who have in contemplation schemes affecting the public health of Canada would doubtless derive great benefit by carefully perusing pages 704 to 711 of this work. Not that they will receive new ideas, but rather that their conception of the duties and requirements of health officers may be enlarged and strengthened—that their belief in the benefits to accrue to the people from the establishment of health boards and sanitary bureaus may be confirmed, and that they may be able to give a reasonable account of the faith that is in them.

Let the book go to the public. Let the public read it, for it is eminently readable, and it will follow that the questions with which they will inevitably ply their physician will for very shame compel him to study those matters more deeply in order to give a satisfactory reply to his intelligent and anxious questioners.

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### Personal.

DR. BURNS has returned from Florida.

DR. WINSTANLEY is still in Southern California.

DR. HOLMES has left Toronto to resume practice in Goderich.

MR. CHRISTOPHER HEATH is preparing a Surgical Dictionary.

DR. S. GRAFTEN (Toronto, '83), has returned from England.

DRS. Osler, and Howard, jr., of Montreal, sailed for Germany last week.

DR. ISAAC BAYLEY BALFOUR has been appointed Professor of Botany at Oxford.

SURGEON GENERAL HUNTER is to be made a Knight Commander of the Order of St. Michael and St. George.

DR. JAMES B. HUNTER has resigned his position on the staff of the New York Skin and Cancer Hospital.

M. TARNIER succeeds the late Professor Depaul, as professor of obstetrics and diseases of women and children.

SURGEON GUNNELL has been appointed Surgeon General of the United States Navy, to succeed Surgeon General Wales.

DR. LUNSFORD P. YANDELL, senior editor of the *Louisville Medical News*, died suddenly at his residence on the 12th ult.

CANADIANS ABROAD—R. K. C. G. McCorkill, Canada; D. A. McCrimmon, Ontario; were admitted L.R.C.P. & S., Edin., in February.

DR. KRAUSS has been elected to represent the Woman's Medical College upon the corporation of the University of Trinity College.

CHEVREUL, the celebrated chemist, who for over fifty years has been director of the Gobelin's factory at Paris, has been placed on the retired list, on full pay. Although ninety-eight years of age, he claims that his forced retirement is premature.

### Miscellaneous.

TALMAGE ON DOCTORS. — Encourage all physicians. You thank him when he brings you up out of an awful crisis of disease; but do you thank him for treating the incipient stages of disease so skilfully that you do not sink as far down as an awful crisis? There is much cheap and heartless wit about the physician; but get sick, and how quickly you send for him. Some say doctors are of more harm than good, and there is a book written, entitled "Every Man His Own Doctor." That author ought to write one more book and entitle it "Every Man His Own Undertaker." Do you think physicians are hard-hearted because they see so much pain? Ah, no! The most eminent surgeon of the last generation in New York came into the clinical department of the New York Medical College when there was a severe operation to be performed upon a little child. The great surgeon said to the students gathered around him: "Gentlemen, there are surgeons here who can do

this just as well as I can. You will excuse me, therefore, if I retire. I cannot endure the sight of suffering as well as I once could." There are so many trials, so many interruptions, so many exhaustions in a physician's life that I rejoice he gets so many encouragements. Before him open all circles of society. He is welcomed in cot and mansion. Children shout when they see his gig coming, and old men, recognizing his step, look up and say, "Doctor, is that you?" He stands between our families and the grave, fighting back the disorders that troop up from their encampments by the cold river. No one ever hears such hearty thanks as the doctor. Under God he makes the blind see, the deaf hear, the lame walk. The path of such is strewn with the benedictions of those whom they have befriended. Perhaps there was in our house an evil hour of foreboding. We thought all hope was gone. The doctor came four times that day. The children put aside their toys. We walked on tip-toe and whispered, and at every sound said, "hush!" How loud the clock ticked, and, with all our care, the banister creaked. The doctor stayed all night and concentrated all his skill. At last the restlessness of the sufferer subsided into a sweet, calm slumber, and the doctor looked around to us and whispered, "The crisis is past." When, propped up with pillows, the sick one sat in the easy chair, and through the lattice the soft south wind tried hard to blow a rose-leaf into the faded cheek, and we were all glad, and each of the children brought a violet or a clover-top from the lawn to the lap of the convalescent, and little Bertha stood on a high chair with the brush smoothing her mother's hair, and it was decided that the restored one might soon ride out for a mile or two, our house was bright again. And as we helped our medical adviser into the gig we saw not that the step was broken or his horse sprung in the knees. For the first time in our life we realized what doctors are worth. In some of our minds among the tenderest of our memories is that of the old family physician.—*Louis. Med. News.*

During the Russo-Turkish war, 1877-78, the combined force of the Russian army numbered 933,000. Of this number 88,166 perished by disease, and 36,455 by wounds received in battle. These results indicate a very inefficient medical service.—*Maryland Med. Journal.*