

Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

THE CANADA MEDICAL RECORD.

Vol. XVI.

MONTREAL, MARCH, 1888.

No. 6.

CONTENTS.

ORIGINAL COMMUNICATIONS.		PROGRESS OF SCIENCE.		Tobacco Heart	140
Valedictory address on behalf of the Faculty by Dr. Proudfoot.....	121	The Treatment of Early Phthisis.....	130	Melancholia.....	140
Valedictory address on behalf of the Graduates by Dr. Thomas.....	122	Pulmonary Consumption as Treated in the Philadelphia Polyclinic.....	131	Soaps in Skin Diseases.....	141
SOCIETY PROCEEDINGS.		The Management of the Anterior Lip of the Uterus.....	134	Dyspepsia Mixture.....	141
Medico Chirurgical Society of Montreal.....	124	The Question of Extraction after Version.....	134	Vague Pains.....	141
CLINICAL NOTES.		Faecal Anemia.....	135	Cystitis.....	141
Typhoid Fever.....	123	Chloasma.....	136	Fracture of the Clavicle.....	141
Non Epileptic Convulsion.....	129	Strictures.....	136	Hyoseyamine for Asthma.....	141
Tape Worm.....	129	The Value of Nitroglycerine in Tinnitus Aurium.....	137	Iritis.....	141
Persistent Headache.....	129	Credé's Method of Placental Expression.....	137	Prognosis in Convulsions.....	141
For Tonsillitis and Pharyngitis.....	129	Colored Light in the Treatment of the Insane.....	138	Bromine in Croup.....	141
Erysipelas Treated with Jabouard's.....	130	On Scarlet Fever and its Treatment.....	138	Flatulence due to Fermentation.....	141
Sodium Chloride as a Prophylactic against Germs.....	130	German Hospital.....	139		
Morphine Habit.....	130	Blepharitis.....	139		
Shoulder Dislocation.....	130	Poetic Feet.....	139		
Laparotomy for Gunshot Wound.....	130	Keith on Hysterectomy in Fibroma.....	140		

Original Communications.

CONVOCATION OF THE UNIVERSITY OF BISHOP'S COLLEGE FOR CONFERRING DEGREES IN THE FACULTY OF MEDICINE, MARCH 28TH, 1888.

VALEDICTORY ADDRESS ON BEHALF OF THE PROFESSORS, BY A. PROUDFOOT, M.D., PROFESSOR OF OPHTHALMOLOGY.

GENTLEMEN GRADUATES:—It is my privilege on this occasion to address to you a few words, and I embrace the opportunity with pleasure.

GENTLEMEN:—You have to-day reached the goal for which you have been striving for four long years; the days of your apprenticeship are over, and you will henceforth be at liberty to put into practice the knowledge which you have acquired.

During your college career, it has been the earnest endeavor of each of your professors, to impart to you as thorough a knowledge of your profession as time and circumstances would permit; and the high standing which some of you have obtained in the examinations through which you have just past is an evidence that their efforts have not been in vain. And believe me, gentlemen, when I tell you, that your professors will follow your future course through life with an anxious interest, as the success of our graduates will determine the continued success of our college.

It has been said that to begin right is half the battle. I wish therefore to give you a few hints upon the subject of *medical ethics*, with which it is the duty of every physician to familiarize himself at the very beginning of his professional career, and never under any circumstances to violate

them when brought in contact with members of the regular profession.

A physician should ever be ready to obey the calls of the sick, and his mind should be endued with the greatness of his mission and the responsibility he ever incurs in its discharge. He should therefore reflect upon the importance of his office, remembering that the ease, health and perhaps the lives of his patients are dependent upon his attention, fidelity and skill. And in his department he should study to unite tenderness with firmness, and condescension with authority, so as to inspire the minds of his patients with respect, confidence and gratitude.

Every case committed to his care should be treated with attention and humanity, reasonable allowance being made for the mental weakness and caprices of the sick. The familiar and confidential intercourse to which the physician is admitted in his professional visits should be used with discretion; and the strictest regard to fidelity and honor. And none of the privacies of personal or domestic life should ever be divulged, even after his professional services have ceased. This rule, however, does not apply in cases of smallpox, diphtheria, scarlet fever, or other contagious or infectious diseases, which he is compelled by law to report to the Sanitary Authorities.

The physician should visit his patients frequently, in order that he may gain a perfect knowledge of their diseases, and be able to meet promptly any change or complication that may arise; he will thus secure the confidence of his patients. Too frequent visiting should, however, be avoided, as they may lay the physician open to the suspicion of interested motives.

Whilst a physician should not be too hasty in forming a gloomy prognosis or in magnifying the importance of his services, it is his imperative duty to warn the friends when danger really exists. And as it is the special mission of the physician to minister hope and comfort to the sick, he should avoid most scrupulously every word or act which may tend to discourage or depress the spirits of his patient. Even where the case is incurable, the physician should not abandon his patient, as he may relieve pain and other symptoms, and thus contribute to his comfort, and diminish the distress and anxiety of his friends.

In cases of real doubt or difficulty consultations should be asked for, as they strengthen the hands of the physician in attendance, and increase the confidence of the patient. I must here remind you that when an hour has been fixed for a consultation, the greatest punctuality must be observed. But circumstances may arise, which will prevent a physician from keeping his appointment, in which case he should, if possible, notify his confrère, and a fresh appointment can be made.

In consultations the attending physician must first examine his patient, after which the consulting physician should have an opportunity of doing so, and of asking such questions as he may deem necessary to satisfy himself, as to the true nature of the case. No statement or discussion should take place before the patient or his friends; but both physicians should retire to a separate room, and after exchanging views upon the case, the attending physician should then communicate the result of their deliberations to the patient and his friends, and give all directions for the further treatment of the case.

The responsibility must then be equally divided between the medical attendants, who share alike the blame of failure or the credit of success. The consulting physician should conscientiously maintain the attending physician in the confidence and good opinion of the family into which he is called, as any attempt on his part, by word or deed, to ingratiate himself and basely supplant the medical attendant, would be most dishonest, and unworthy any member of an honorable profession. And, gentlemen, there is no profession from the members of which there is required a higher standard of morality than the medical. Let therefore your habits be regular; do not devote too much time to pleasure, politics or any other pursuit which may incapacitate you for the faith-

ful performance of your professional duties. And here let me warn you against the far too prevalent habits of "*nipping and smoking.*" It is incumbent upon the members of our profession to be temperate in all things, with eyes clear, hands steady and brain unclouded, ready to act on any emergency, where the life of a fellow-creature may be in danger.

Can you imagine anything more distasteful to a delicate and refined lady than to have a physician ushered into her presence, whose breath is redolent of the fumes of Old Rye, and whose clothes are reeking with the odor of stale tobacco? In these degenerate days, I know that it is useless for me to tell you not to smoke. I will therefore content myself with earnestly advising you to reserve your pipe or cigar until after you have made your daily round of visits. And, gentlemen, one word more and I have finished.

Do not get discouraged if practice does not come quickly, and be led to make the fatal mistake of having flaming advertisements or reports of operations and cases inserted in the daily papers. These are the common practices of the quack or empiric, and are considered discreditable to members of the regular profession. Your time can be profitably spent in making careful notes of every case that may come under your observation; from the daily papers you can post yourself upon the news of the day, and from medical journals, for one or two of which I would advise you to subscribe, you will be able to keep yourselves *au fait* in all matters more closely connected with your profession.

And now, gentlemen, in the name of your professors, I bid you good-bye and Godspeed.

VALEDICTORY ADDRESS ON BEHALF OF THE GRADUATING CLASS.

BY DR. S. A. A. THOMAS.

WORTHY CHANCELLOR, DEAR PROFESSORS, LADIES AND GENTLEMEN.

I regret that I have to express my thoughts in a language for which I have much admiration, but which, owing to my early training, I speak but imperfectly; however, trusting to your generosity and to your kindness, I have accepted the honor of addressing you this day in behalf of the graduating class, although this could have been better done by any of my confrères.

At last we have completed our 4 years of student's life, rather of college life,—for the medical

man, in order to keep pace with the times, must remain a student for ever—and have had conferred upon us the often coveted degree of C. M., M. D. Such is the reward of our energy and perseverance. The price is great, the value thereof cannot be overestimated. As our Alma Mater has thought us worthy of admission into the ranks of her graduates, let us, fellow-graduates, prove ourselves worthy sons of such a grand University.

Indeed, this is a happy day for us, for, within these walls, we see the face of many and many friends who have gathered to congratulate us and to rejoice with us. How auspicious the future, surely, with so many friends to stand by us, we cannot help but succeed in our noble profession. We, the graduates, thank you, ladies and gentlemen, to have come in such a great number to witness this our happiest day.

Although our college days are over, at the feet of our professors we have learned to reverence the medical profession, and will ever endeavor to promote its welfare at all times.

But as this is a day of gladness and of jubilation and of mutual congratulations, it is also a day of sadness and of sorrow. To-day, we press—doubtless, many of us—the hand of some good and faithful friends whom we shall never see again. To-day, we have to bid farewell to our dear professors, with whom we have been so intimately connected during the past 4 years; ever we have found them sympathisers, friends and true gentlemen. In parting with you, dear professors, we heartily thank you for the knowledge you have imparted unto us, for your kindness in and out of the lecture room; we gladly bear testimony to your able teaching, and to the painstaking care you ever employed to fit us to answer the calls of suffering humanity.

We recognize your efforts to promote true medical education, both out and in college. True it is we, the class of 88, grumbled a great deal when you made the examinations in ophthalmology and in diseases of children compulsory, but to-day we forgive you, for we know that it was your enthusiasm in behalf of the promotion of medical education, your aim at making Bishop's the leading school, that caused you to take such a step.

By the way, ladies and gentlemen, should any one of you—I trust, that you may never need to—have something wrong with his or her eye, you need not call in a specialist if you are in the vicinity of a Bishop's graduate, for every man graduating from

our Alma Mater ought to be capable to perform the most difficult operations.

Our college life has not been an unhappy one; although we had to study hard, yet we had occasionally our recreations, and such recreations as medicos alone know how to take.

I need not, ladies and gentlemen, describe to you the different stages through which we passed during the last few days,—I refer to the examinations. I would not for a great deal have to undergo the same strain as I did during the last week. To the professor the day of examinations seems to be a wedding-day; see him coming in, all smiles and radiant with joy. To the candidate, such a day is more like a funeral than anything else, see him and tell me if I am mistaken; his face anxious, expression doubtful, countenance somewhat cachetic, his eye sunken and lifeless, pulse rapid and wiry, at times there is dysphagia and aphonia, especially when sitting before examination papers, and the questions do not, at first sight, appear to be practical or of vital importance. In short, ladies and gentlemen, the candidate looks more like a revivalist, a brother to Sam Jones and Sam Small. Indeed! those have been lonely and long hours; but to-day we look back with joy and satisfaction over our trials.

All is well that ends well: we are through now, and we wish our fellow-students, whom we leave behind us, every success in their coming years; may they prove themselves an honor to our Alma Mater.

We thank our professor, Dr. Proudfoot, for the sound and practical advice contained in his valedictory on behalf of the Faculty; it will be our aim to abide by it.

In all probability, this is the last time we meet together; the calls of interest, the appeals of ambition, the demand of our families will cause our paths in life to be widely divergent.

Some of us may sleep beneath the sands of Africa and some beneath the ice of Alaska some may find a resting place in the bosom of the ocean, whilst some we trust will remain in this dear old city of Montreal; but wherever we may go, let us cherish the recollections of our Alma Mater, and let us enshrine our student's association with the flowers of everlasting friendship and true devotion.

In saying farewell, we wish our Professors every success, and we hope and trust that they may be long spared to communicate their sound and

practical teaching. Farewell to our former fellow students, whom we leave behind; we expect much from you, and we trust that we shall not be disappointed in our expectations of distinguishing yourselves in your coming examinations.

Ladies and Gentlemen, once more thank you for your attendance this afternoon, and to one and all, in behalf of the class of '88, I bid a hearty farewell.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Dec. 9th, 1887 (continued).

Removal of Eight Calculi.—Dr. RODDICK exhibited eight large calculi which he had removed from an old gentleman last summer by the lateral operation. The stones weighed $2\frac{1}{2}$ ozs. At the time of the operation the patient was in very bad health and there was much pus in the urine. He died some two days after the operation of uræmia. Although no post-mortem was allowed, there is little doubt that the kidneys were very seriously affected. In this case the supra-pubic operation was contemplated, but the lateral was preferred on account of the small capacity of the bladder, which would only hold $2\frac{1}{2}$ oz. of water.

Stated Meeting, December 23rd, 1887.

JAMES PERRIGO, M.D., PRESIDENT, IN THE
CHAIR.

PATHOLOGICAL SPECIMENS.

Tuberculous Knee-Joint.—Dr. BELL exhibited a leg recently amputated at the junction of the middle and upper thirds, for tuberculosis of the knee-joint. A longitudinal section was made to show the condition of the joint. Dr. B. gave the following history:

P. F., aged 30, a pale, emaciated man, was admitted to hospital on the 19th of December with the following history: He began to suffer from a painful and swollen knee twelve years ago, which is vaguely attributed to injury. The knee has grown steadily worse up to the present, incapacitating him for work for the greater part of the time. For about four years he has been confined to his bed with it. Two years ago he was

treated by a quack, who blistered the leg in large patches above and below the knee, and then applied salt pork to the abraded surfaces. These sores never healed, and an attack of erysipelas, which occurred a few months ago, caused extensive burrowing of pus both in the thigh and calf. On admission, the patient's general condition and the condition of the soft parts in the leg and lower third of the thigh were very unpromising indeed. On this account the idea of excising the knee-joint was abandoned, and the thigh amputated at the junction of the upper and middle thirds (it being impossible to secure sufficient healthy tissue for flaps at a lower point). The progress of the patient was uninterrupted after amputation, and he was discharged at the end of three weeks with a small sinus still open at the inner angle of the flap. The knee-joint, when sawn through from above downwards, although showing extensive and widely distributed disease, was yet in a condition suitable for resection, had the patient's general health been better and the soft parts in the leg and thigh less extensively destroyed.

Dr. RODDICK thought that as far as the condition of the joint itself was concerned, it was a typical case for excision, but the condition of the soft parts necessitated amputation.

Dr. SHEPHERD saw the case three months before; did not think there was pus in the joint at that time, and was struck at the time of the operation with the amount of suppuration in the soft parts about the joint. He thought the amputation might with safety have been made a little lower.

Tubing in Diphtheria.—Dr. JOHNSTON showed the respiratory organs in a case of diphtheria which had proved fatal two days after the performance of intubation, the tube being shown *in situ*. The lungs were for the most part in a state of acute emphysema, but showed a few small patches of collapse with commencing pneumonia. The tube was seen *in situ*, and was not obstructed. The membrane had extended into the first bronchi. A slight diphtheritic exudation was seen over the tonsils. The tube had produced no necrosis of the parts with which it lay in contact.

Dr. MAJOR stated that the patient, a girl aged 3 years, had been temporarily relieved by the use of the tube, but had died two days later.

Dr. GEO. ROSS had observed shortly before death that physical signs of severe bronchitis had existed.

Dr. MAJOR, in answer to Dr. Roddick, said that the longest time he had left a tube in the larynx was ten days; there was only slight erosion of one ventricular band, but no ulceration. Tubes are very liable to be coughed up.

Angioma of the Liver.—Dr. JOHNSTON also exhibited a microscopic section from a cavernous angioma he had found in an amyloid liver. The walls of the cavernous spaces were not affected by the amyloid change. The case was of interest in connection with the question as to whether the angioma arose in connection with the hepatic artery or the portal vein. This point had been left obscure, as attempts to inject angiomata by these vessels had led to contradictory results. As amyloid affects primarily the branches of the hepatic artery, this, the angioma being practically unaffected, would in this case be solely of portal origin. The minute spots of amyloid change in it being accounted for by the fact that the hepatic artery nourishes all the structures of the liver.

Physiological and Pathological Reversion.—Dr. T. W. MILLS read a paper on this subject.

Dr. SHEPHERD referred to the extension of the principles of evolution to all branches of science. He has long been a supporter of evolution from a morphological point of view, and he believed the physiological aspect as developed by Dr. Mills affords quite as broad a field for investigation. Just as the development of the embryo is the compressed history of the development of the individual, so Dr. Mills' paper shows that death tells us the tale of development backwards.

Dr. STEWART, referring to Dr. Mills' remarks on the dissolution of the circulation, said that in old age a man dies along the track of the circulation. Some one says that death from old age was the evolution of dissolution.

Laboratory Notes on Papoid Digestion.—Dr. R. RUTTAN read a short paper on the above subject, which will be found in the February number of this JOURNAL.

Dr. GEO. ROSS said he had been using the drug for some time in the hospital with satisfactory results in diphtheria. One of the marked effects of the application of the solution was the entire suppression of the characteristic factor of the disease. He used a 5 per cent. solution, and the atmosphere of the ward was kept quite fresh and sweet. It certainly seems to dissolve the membrane.

Dr. STEWART suggested its use as an escharotic for the removal of tuberculous infiltrations.

Dr. GODFREY said he was now using a 5 per cent. solution to destroy a hard scirrhous cancer of the heart, and so far was thoroughly satisfied with its action.

Abdominal section for Sarcoma.—Dr. W. GARDNER exhibited specimens from a case of sarcoma of the uterus and ovaries on which he had operated. Rapid recurrence took place with death on the seventh week. Dr. Gardner gave the following account of the case and the operation:

The patient was sent in by Dr. T. L. Brown, of Melbourne, who was consulted only a few days previously for some bladder symptoms, when he recognized the rapidly growing pelvic and abdominal tumor. She was a fair-haired, light complexioned, vivacious, and very procacious child, always delicate. Menstruation had not appeared, and the only evidence of approaching puberty was scanty pubic hair. The tumor evidently sprung from the pelvis but had risen to the abdomen, was nodular and scarcely moveable. Though recognizing its probably malignant nature, operation was decided on. The growth was a friable mass, with a few cysts adherent to omentum, intestines, posterior surface of bladder, and everything else in the pelvis. Neither uterus nor ovaries were distinguishable. The cavity was washed out and a drainage-tube inserted. Recovery was scarcely clouded by any symptom of importance. Appetite was regained to a considerable extent, but it was not long before a return of the growth was perceptible, and it went on with mushroom-like rapidity till the abdomen was greatly distended, and she died from exhaustion. The tumor was examined by Dr. Johnston and pronounced by him to be sarcoma.

Stated Meeting, January 6th, 1888.

T. G. RODDICK, M. D., IN THE CHAIR.

PATHOLOGICAL SPECIMENS.

Dislocation of the Sixth Cervical Vertebra.—Dr. HUTCHISON exhibited the dislocated cervical vertebra, and gave the following history:—

H. C., aged 37 years, a brakeman on G.T.R., while walking on top of a freight car, which was running at the rate of three miles an hour, fell between two cars, the rear one throwing him clear off the rails; he fell on his shoulders. The accident took place at 5 p.m., Oct. 29th, 1887. He was removed to the van, and brought to Montreal, —a distance of forty miles. During the journey he suffered a great deal of pain in both arms; did

not lose consciousness. I visited him at 8:30 o'clock the same evening, and found him conscious, paraplegic with partial paralysis of arms. The arms were thrown at an angle to the body, causing great pain on any attempt being made to restore them to sides. There was preternatural mobility and crepitus in region of fifth cervical vertebra. The vertebral line was thrown forward above the seat of injury; pupils, pulse, temperature and respiration normal. Assisted by Dr. Kinloch, extension was practiced without an anæsthetic, which relieved the pain in arms, and left patient in a comfortable position.

Oct. 30th, 10 a.m.—Patient slept several hours during night, suffered no pain. Noticed slight contraction of pupils and slight stertorous breathing. Urine drawn off with catheter. 4 p.m.—Stertor increasing; temperature normal; partially comatose. 7 p.m.—Death ensued twenty-six hours after accident; during twenty-two and a half hours of that time the patient was perfectly conscious. From the faint crepitus obtained the case was thought to be one of fracture.

Dr. RODDICK referred to a similar case of cervical dislocation that was successfully treated by extension by the late Dr. G. W. Campbell. Dr. R. had practiced extension in several cases, but unsuccessfully.

Anencephalic Monster.—Dr. GURD exhibited an anencephalic monster, showing a membranous sac filled with fluid corresponding to the cranium. This foetus appeared to be about at the sixth month, and was dead at birth. The mother, a somewhat delicate patient, had suffered a severe fright early in gestation.

Dr. MILLS said it illustrated his paper read at the previous meeting. The development of this foetus, so far as the brain is concerned, seems to have been arrested in a stage of its existence corresponding somewhat to that of the lowest vertebrates.

Drs. Wyatt Johnston, J. C. Cameron and Shepherd were appointed to examine the foetus and to report at a subsequent meeting.

A case of Nævus.—Dr. RODDICK exhibited a foot removed by Syne's amputation. The patient, a woman, 30 years of age, had a nævus on the dorsum of the foot, which grew very slowly until she married, some ten years ago, when with each pregnancy it increased considerably until it had assumed enormous dimensions. The tissues of the foot, including all the toes, had become

thickened, resembling elephantiasis. Especially since the birth of the last child, three months ago the increase in growth was very marked. Lately quite an extensive slough, amounting almost to gangrene, had formed on two of the affected toes. This caused troublesome and often alarming hemorrhage. Owing to the thickened elephantive condition of the tissues of the foot amputation was deemed the only feasible procedure. The posterior tibial artery and nerve were found enlarged to three or four times their normal size. The glands in the groin were also very much enlarged at the time of operation.

Stated Meeting, January 20th, 1888.

T. G. RODDICK, M.D., IN THE CHAIR.

PATHOLOGICAL SPECIMENS.

Dr. G. ARMSTRONG exhibited the brains from two cases of cerebral disease.

(1) *A case of Apoplexy.*—The first brain shown was removed from a man seven hours after death, occurring at the age of 56 years, from apoplexy. The patient was an Englishman, enjoyed robust health, but since coming to Canada has been stronger than he was at home. For a fortnight before death he had been at home, complaining of weakness, anorexia, a little frontal headache, and rheumatic pains about arms, legs and back. No elevation of temperature or acceleration of pulse; tongue coated; bowels moved by eating a little fruit. On the morning of the day of his death he awoke, feeling particularly bright and cheerful. Expressed himself as feeling stronger, and thought he would be able to return to office in a few days. About 8 a.m. he went to the store and suddenly called for help, sank on to the floor unconscious, and in one hour was dead, never having regained consciousness. Dr. Johnston kindly performed the autopsy for me. We found, on removing skull-cap, a large clot in right frontal region, just beneath the arachnoid. On removing the brain the ventricles were found distended with blood, death having resulted from the blood passing along the iter into the fourth ventricle, and thus producing pressure sufficient to paralyse the centres of organic life. On closer examination the blood was found to come from a rupture of a vessel of the right corpus striatum. Dr. Johnston afterwards found that the vessels were fattily degenerated. Heart and kidneys were examined and found normal.

(2) *Cerebral Syphilis*.—The second brain shown was removed from a man who died at the age of 62. Dr. Armstrong gave the following account of the case. The patient claims to have enjoyed good health up to June, 1885. At this time while walking to his office one morning, he fell down but says he retained consciousness all the time. Some men passing helped him up, and he went on to the office, but only remained a short time and then walked home again. I saw him soon afterwards, when I found him quite rational. There was present no paralysis of motion or sensation. He told me that for some time his appetite had been poor, and he did not enjoy his pipe as much as usual. For the past two years he had suffered from frequent micturition, and had an enlarged prostate. After he had micturated I drew off 10 ounces of slightly turbid urine with the catheter. Urine contained a considerable quantity of pus; reaction acid. No headache or dimness of vision. On the 14th November, 1885, when dressing, he fell suddenly to the floor, but did not lose consciousness. When his wife picked him up she thought he had no power in his limbs; but when I saw him a few hours later I could detect no paralysis of motion or sensation, but he was partially aphasic. He could answer questions correctly and could speak in short sentences, but stopped in the middle of a long sentence. Although previously a good penman, his present scroll was illegible. A peculiar subjective symptom at this time was his hearing pleasant music, especially in the left side of his head. He rather enjoyed listening to it. All the parts were carried correctly along together. The treatment at this time was Hg. and large doses of Pot. Iod. His condition improved somewhat, but aphasia never entirely disappeared. About six weeks ago he became suddenly hemiplegic on the right side, death finally resulting from exhaustion and septic poisoning from large gangrenous bedsores. Dr. Johnston kindly performed the autopsy for me. We found a large gumma occupying the third left frontal convolution, and a patch of softening extending almost quite across the left internal capsule, due probably, Dr. Johnston thinks, to an embolus. It is very satisfactory to find such well marked lesions, which accounts so well for the symptoms from which the man died.

Discussion.—Dr. Buller thought that the tumor must have produced double optic neuritis. Larger doses of potassium iodide, 40 to 60 grains three

times a day, might have produced very beneficial results in this case. Referring to the subjective symptoms of the patient, Dr. B. said these were often caused by perturbation of the nerve centres, and were the usual early symptoms of insanity.

Dr. TRENHOLME strongly advocated the administration of large doses of iodide of potassium in cerebral syphilis.

Dr. RODDICK could not understand how the wife could have been inoculated by the husband, as he had tertiary syphilis.

Dr. ARMSTRONG, in reply, stated that the wife had all the symptoms of secondary syphilis about the time of the husband's attack. In answer to a question from Dr. Stewart, he said that the patient at no time exhibited facial paralysis or any other affection of the motor system.

Membranous Croup.—Dr. JOHNSTON exhibited for Dr. R. J. B. Howard a specimen which he thought an example of membranous croup as distinguished from diphtheria. The case was a sporadic one, and the disease primary in the larynx. No membrane had ever been seen in the fauces. Intubation had been performed by Dr. Major. The child had died suddenly two days later. At the autopsy the tube was found plugged with mucus. The larynx and trachea showed a uniform sheathing of membrane which formed a cast of the trachea, but was nowhere adherent. The same condition was seen on the posterior surface of the epiglottis. The only spot where the membrane was adherent was just at the rima, on each side, over a small area a quarter of an inch square. The glands were not enlarged. On detaching the membrane the mucosa looked healthy; on microscopic examination it was found to show signs of proliferation, but was nowhere necrotic, except where membrane was adherent. In about 15 cases of diphtheria he had dissected in the last 3½ years, this was the only one which had appeared to bear out Virchow's distinction, that in croup a necrosis of the mucosa was not the initial lesion.

Discussion.—In reply to Dr. STEWART, Dr. JOHNSTON said the cause of death was suffocation, from the child having coughed up the tube. The constitutional symptoms were not marked.

Dr. J. A. MACDONALD believed that tracheotomy would have saved the patient's life.

Dr. SHEPHERD agreed with Dr. MacDonald that this was a case where tracheotomy was especially indicated. He could not see, clinically, any

great difference between membranous croup and diphtheria. He did not think diphtheria was an extremely infectious disease. When whole families were infected they were usually exposed to the same influences, such as unhealthy surroundings, bad drains, etc. He did not believe diphtheria was a modern disease. The so-called putrid sore throat of former days was probably diphtheria.

Dr. ARMSTRONG thought that there was a good clinical difference between these two diseases. True croup is not infectious, and there is no glandular enlargement or pharyngeal trouble accompanying the laryngeal affection.

Dr. TRENHOLME had seen many cases of true diphtheria where the membrane was confined to the larynx.

Dr. RODDICK said he was convinced that croup was one thing and diphtheria quite another. He remembered his first case of diphtheria, and it was widely different from any form of croup that preceded it. Undoubtedly the two diseases may occur together, as with tonsillitis and diphtheria. The line of distinction between the latter two diseases was much harder to draw.

Dr. BULLER believed the diseases were distinct. There is certainly a great difference between croupous and diphtheritic conjunctivitis. The plastic exudation of the former affection is accompanied by no severe constitutional symptoms, and the inflammation is confined to the surface. The diphtheritic is well defined and virulent; the whole lid becomes tense and brauny; the disease is destructive and deep-seated. The two processes are quite distinct in the conjunctiva, and it is difficult to see why they should not be so in other membranes.

Dr. BLACKADER said that the difference between pharyngeal and laryngeal diphtheria was due to differences in the nature of the submucous tissues; in the former the deeper tissues were not so closely attached. There was no difference in the microscopic appearance of croupous and diphtheritic membrane, but he believed it was, clinically, always safest to treat cases of membranous croup as diphtheria.

Trichorexis Nodosa.—Dr. SHEPHERD presented specimens of hair affected with the above disease taken from the moustache and eyebrows of a reddish-haired man, aged 35. The nodes on the hair were pigmented. The disease was first noticed two years ago, and that time the left side of the moustache only was affected. He found he

could not grow hair on this side of his moustache beyond a certain length, so he shaved, and for the next four months the disease did not appear; but as the hair grew larger, it reappeared and spread to the right side of moustache as well. During the last two months the same disease had affected his eyebrows. Many of the hairs had several nodules and many were split at the ends. The patient is very certain the affection is not due to pulling at his moustache. Dr. Shepherd remarked that this was a very rare disease, and was characterised by having nodular swellings along the shaft of the hair, and the hair breaks easily, usually through one of the nodules. When broken the hair has a brush-like end. *Trichorexis nodosa* is not a parasitic disease. It commonly affects the beard. The first symptoms noticed by patient are nodosities of the shaft of the hair and great brittleness, the part of fracture being at one of the nodules. Each hair has four or five of these nodes, which in people with reddish hair are pigmented. Nothing is known of the cause. Something is due to mechanical causes. By some the lesion is regarded as due to the gradual drying of the cortical substance, whilst others look upon it as an atrophy of the medulla occurring at different points, especially at the points where the nodes are. The hair roots are unchanged or slightly atrophied. Treatment is of no avail.

Clinical Notes.

TYPHOID FEVER.

The general method adopted at the Jefferson Hospital by Dr. Jas. C. Wilson, in the treatment of typhoid or enteric fever, is to give calomel (gr. viiss-x), and sodium bicarbonate (gr. x) at a single dose, at night, to be repeated once or twice, if the case is in its first week; if in the second week it is not repeated, and after the tenth day of the disease it is only administered if required by the state of the bowels. Diarrhoea, however, is not to be considered as a contra-indication to the mercurial. When the evacuations are excessive suppositories of opium (aq. extract gr. j) are used at night. Enemata of thin gruel may be occasionally resorted to for the relief of constipation. Cold sponging of the body is resorted to twice in the twenty-four hours as a routine measure; hyperpyrexia requires more frequent applications. Carbolic acid (gr. j) and tincture of iodine (gtt. ij) are given from the beginning, every two hours during the day; every three hours at night. Antipyrine (gr. x-xv) is given in a single dose when the temperature is over 104°. Alcohol is not necessarily a part of the treatment.

NON-EPILEPTIC CONVULSIONS.

The patient has been subject to these attacks for fifteen years. The eyes do not move in harmony, owing to paresis of one of the ocular muscles. The third, fourth, fifth and sixth nerves may be affected. There has probably been a lesion in the middle fossa of the skull, pressing upon these nerves. The lesion is most likely a coarse one. The seizures are symptomatic.

Treatment: iodide of sodium, one scruple, thrice daily.

Bartholow says that when pilocarpine, mercury, and iodide of potassium are given together, the action of the remedies taken is hastened, in gumata of the brain, and that he has obtained the most happy results therefrom.

Prof. Keyser considers this a most excellent antiphlogistic in iritis:

R Hydrargyri chloridi corrosivi, gr. 1-20
Extracti belladonnæ.....gr. 1-10 M.
In pill, ten minutes after each meal.

Before his clinic a few weeks ago, Prof. Goodman removed at one operation both breasts of a woman who has suffered severely for many years from interstitial lobular mastitis. Healing was by first intention, and the relief was complete.

In typhoid fever, Prof. Waugh has so far had good success with sulphocarbonate of zinc. A case was shown at his clinic which had come for treatment when suffering with fetid diarrhœa, high fever and hemorrhage from the bowels. Sulphocarbonate of zinc at once stopped the hemorrhages, removed the fetor from the stools, and reduced the temperature two degrees.

This makes the eighth case in which Prof. Waugh has tried this preparation with similar results.

Prof. Garretson is fond of this treatment for a sessile nasal polypus difficult to snare. He firmly constricts the polypus by means of an ordinary pair of dressing forceps, and allows them to hang on the growth till it sloughs off.

Try the following prescription to abort an attack of acute bronchitis. Prof. H. C. Wood says that it is very valuable:

R Potassii citratis..... $\frac{ij}{j}$
Syrupi ipecacuanhæ $\frac{f \text{ } \frac{ij}{j}}$
Succus limonis $\frac{f \text{ } \frac{ij}{j}}$
Aqua..... $\frac{\text{ss} \text{ } \text{ij}}{j}$

M. S.—Two teaspoonfuls every three hours.

For myalgia in a strong man, Prof Waugh gave

R Ammonii chloridi.....gr. xxx
Extracti belladonnæ.....gr. $\frac{1}{2}$

M. S.—As a dose three times a day.

In the case of gastralgia, Dr. Pepper was led to suspect a malignant complication, because of the absence of free hydrochloric acid in the stomach six hours after meals, although the prominent symptoms of cancer of the stomach were absent. Marked pulsation at the supra-sternal notch and

over the innominate, in aortic in sufficiency, should not be mistaken for aneurism. The beat is not expansile, as in aneurism. (Osler)

Dropsy does not occur in mitral insufficiency unless tricuspid insufficiency co-exists. (Osler).

When convulsions first occur after the thirtieth year, and usually epileptiform in character, suspicion points to cerebral tumor. (Osler).

Chills and fever, intermittent high temperature, and pus in urine, the urine being acid, point to pyelitis. (Osler).

Several cases of catarrhal jaundice yielded rapidly to the rectal injection of cold water, one or two quarts, at a temperature of from 50° to 60° F., as recommended by Krull.

TAPE WORM.

FROM PHILADELPHIA HOSPITAL.

The most successful way to get rid of him is by making him let go with his hooks. You must give him a narcotic remedy. We have one remedy that is the best for the armed worm, "tœnia solium." Pomegranate I do not believe will ever fail, if properly applied. First clear out the canal. A purgative will not do this. Give remedies that liquefy, such as phosphate of soda, for a few days, then an active purge. The sodium phosphate must be given in the intervals of digestion, in decided doses. Then give:

Pomegranate, bark.....oz. iv ;
Aq. font.....O ij.

Boil down to Oj, and give largely.

(Bartholow)

PERSISTENT HEADACHE.

This man is employed at the chemical works.

There is no malady which gives as much trouble as headache. Guarana and such remedies are only good for a time, which speedily expires. The fifth nerve is affected in this case. The remedies that will cure this are few. Treatment: remedies that modify the functions of nutrition; change of occupation, habits, life; amount and quality of air in the sleeping-room, etc. The most valuable remedy is Donovan's solution; the biniodide has more power than any other to destroy germs in the alimentary canal, which we believe to cause intestinal disturbance in this case.

R Liq. arsenii et hydrarg. iod. gtt. iij, ter in die.

(Bartholow.)

FOR TONSILLITIS AND PHARYNGITIS.

Prof. Woodbury says that glycerites of tannic and of gallic acid are valuable preparations for the physician to have in his office, to serve as applications by brush or in the form of a spray to sore throat, inflamed tonsils, and the like, and should have been included in the last revision of the Pharmacopœia.

ERYSIPELAS TREATED WITH JABORANDI.

A poor woman was brought into the Medico-Chirurgical Hospital, with an enormous peri-typhilitic abscess, which had been neglected. It pointed in the groin and on the thigh. The whole surrounding region was erysipelatous, and the disease had also appeared on the face. Fluid extract of jaborandi was at once given by Prof. Waugh in doses of M xx every four hours; and even before the abscess was opened the erysipelas was under control. Enormous quantities of foetid pus were evacuated from the abscess which had burrowed down into the glutei. The woman is being supported with peptonoids, wine, iron and quinine.

SODIUM CHLORIDE AS A PROPHYLACTIC AGAINST GERMS.

Prof. Woodbury advises a plentiful use of common salt in one's food, for he thinks that it acts as a preventive to zymotic diseases, and that when such diseases do come, they are much lighter in persons accustomed to using salt.

Have a thermometer in a sick-room, and see that the temperature is kept at from 70° to 75° Fahrenheit. Keep perfumes out of the sick-room; they soon have a stale odor and are offensive to the patient; keep visitors out, also; they are still more so.—PROF. ATKINSON.

MORPHINE HABIT.

Dr. Wilson showed a case of morphine habit at the Philadelphia Hospital, January 14, 1883, in which one drachm of morphine only lasted the patient four or five days. The drug was originally prescribed by a physician for the relief of pain in hip-joint disease. In treating these cases it is indispensable that the physician himself administer any morphine required, as few nurses can resist the pitiful appeals of a victim of this habit while under treatment. The treatment must be largely moral in such cases.

SHOULDER DISLOCATION.

After several vain attempts to reduce a sub-glenoid luxation by rotation, Dr. Janney succeeded by making traction directly away from the shoulder. He declared that when the head of the humerus is lodged beneath the glenoid process of the scapula, rotation is often useless.

LAPAROTOMY FOR GUNSHOT WOUND.

Dr. T. G. Morton performed a laparotomy on a man, on December 29, 1887. The case was one of gunshot wound. The bullet was found and extracted. Four days after the operation the patient was doing well.

Progress of Science.

THE TREATMENT OF EARLY PHTHISIS.

By J. MILNER FOTHERGILL, M. D.,

Physician to the City of London Hospital for Diseases of the Chest.

When the student has left the examination table and entered upon actual practice, he sees other phases of disease than those most familiar to him at the hospital—except in the out-patient department. The extraordinary and unusual cases upstairs, which absorb so much of the visiting physician's time, become so much more extraordinary and unusual that they reach vanishing point, while colds, catarrhs, exanthemata, indigestion, bronchitis, and phthisis constantly come before him. If he be a careful observer he will soon learn to detect the early onset of phthisis pulmonalis, and this will at once put the case on a line of appropriate treatment in order to prevent the case becoming worse, and, if possible, to inaugurate improvement; and the earlier this is done, the better the prospect of success.

Beyond the physical examination of the chest, the usual phenomena complained of are languor, loss of appetite, and, with that, loss of flesh, and night sweats. The burning of the palms and soles is not so common now as it used to be. As to the hectic flush on the cheeks—once the theme of poets and novelists—it is rarely found, at least among town-dwellers. "The red flush on his cheek told that consumption had already hoisted his bloody flag of 'No Surrender,'" wrote the author of "Guy Livingston." Rather now it is a pallid and greasy skin, which carries with it a grave prognosis. There is a loss of body weight with an increase of lowly connective tissue in the lungs (This it is which gives the physical signs of early phthisis. Impaired elasticity altering the character of the breath sounds; increased density affects the percussion note, and causes the lung to be a better conductor of sound), while the night sweats drain away the body salts. If the patient be a girl there may be menorrhagia; but far away more frequently there is amenorrhœa more or less complete.

How does such a case stand from a therapeutic point of view? There is (1) increased outgoings otherwise increased body expenditure. There is (2) defective body income. To meet these, to decrease the one, and to improve the other, is what is our plain duty.

Without forgetting that each case of phthisis has its own individual characteristics, which must be allowed for in each case, some useful, broad rules may be laid down. To my mind the first matter to be looked to is the "outgoings." No one entertains any misgivings about arresting a diarrhœa, which obviously weakens the body-powers. If there be vomiting, the necessity for

quelling it is patent to all. Where the patient is a woman it is well to lessen the catemenial loss and so conserve the powers. But in early phthisis menorrhagia is rare. Rather the system cuts down, or altogether cuts off a discharge to which it is unequal, and the return of the menses is hailed by all as a trustworthy indication of gathering power. But there is a discharge very common in early phthisis too little regarded, and that is leucorrhœa. This drain is apt to fasten on a weak organism and to cling to it tenaciously. Yet it is readily amenable to treatment—if the patient can be got to do as told. There is, however, a deep-rooted aversion to the use of vaginal injections among British women—at least such has been my personal experience.

One other outgoing there is remaining to be considered, and that is the justly dreaded night sweats. In very early days of practice our means of checking night sweats were very inadequate to the end sought. My memory can call up a whole series of cases well known to me where the patients dwindled away before our eyes; because our tonics, cod-liver oil and port wine, were unequal to meeting the drain of the night sweats. We were feeble because we walked in the darkness of ignorance, before the dawn of efficient anti-hydrotics. When Professor Sydney Ringer introduced belladonna for the arrest of night sweats, to my mind, he revolutionized the prospects of most cases of phthisis.

But it must be given in an efficient dose. I never begin with less than one seventy-fifth $\frac{1}{75}$ of a grain of atropine. If a small dose be given and then the remedy be abandoned because this is insufficient, it is scarcely "homicide by misadventure" to my way of thinking. It should be pushed to one twenty-fifth $\frac{1}{25}$ every night, *i. e.*, in practice, not at the examination table. As soon as the drain of blood salts is checked the appetite returns, usually without resort to bitter tonics.

So much for the first line of attack.

The second line is to increase the body-income.

At one well-known hospital quinine and cod-liver oil constitute the treatment of phthisis pulmonalis, and a very good line, too; but scarcely quite elastic enough. But the principle is there, *viz.*, to give tonic to the system, and to supply fat for the building up of healthy tissue. It is certainly good practice to give a bitter tonic, as strychnia, for instance, with a mineral acid, as phosphoric acid; with a little sulphate of magnesia, if constipation be present, as is very often the case. If the tongue carry a brown hue, indicative of hepatic disturbance, then sulphate of soda must be substituted for the Epsom salts, *malgre* its nauseous taste.

The dietary should consist of fish, fat, and milk puddings, with a little meat. When the stomach is upset, then a little bismuth and soda may be given instead of the tonic, and the food should consist of milk well boiled with some of the

many prepared foods on the market; and beef-tea, with the same, or broken biscuit.

When the gastric disturbance is allayed, then it is well to go back to the tonic. Blisters are of questionable advantage; and it is difficult to point out the indications for their use. Cod-liver oil may be given when the tongue is clean and the appetite vigorous. It should always be exhibited *after food*. The same may be said of chalybeats. These measures should be accompanied by fresh air—the purer the better. Bright sunlight, cheerful surroundings, pleasant companions are matters of no little moment. As to a sojourn in a high-lying Swiss valley, it is in fashion at the present time, though as one of the very best physicians in Great Britain remarked:—"The cases which will get well at Davos are those which will get well elsewhere" under intelligent management." There is no altitude too lofty for the tubercle bacillus to climb, if there exist a bit of tuberculous lung to afford it a congenial home. Certainly, a low-lying, damp locality, on a clay soil, must be abandoned for gravel or a chalk down; else the case will probably take the wrong direction.

English home comforts and food customs can be set against so many hours of sunshine in a mountain valley. That, I believe, is the coming creed. Such, then, is the second line of attack upon pulmonary phthisis.

Now, for two minor or auxiliary matters. One is the use of inhalations. Plain steam is good in irritative cough with dry air-tubes. Iodine, carbolic acid, eucalyptus, or Friar's balsam, or ordinary terebene are often excellent medications, and allay cough. The other is a resort to a cough linctus. On this matter opinions may differ. Some use paregoric to allay ceaseless cough, and do a great deal of harm very often therewith, though paregoric is the least objectionable of "cough medicines." The reckless resort to something "to allay the cough" has, in my experience, been too frequently followed by disaster to recommend itself to a thoughtful practitioner. Something to allay cough and preserve sleep at nights certainly does more good than harm; but "cough stuff" in the day is my abhorrence. It may be no more than prejudice, perhaps.

Such, then, are the main lines on which a case of consumption in its early stages has to be carried on; and on the whole it be found to be not unsatisfactory.—*From Hospital Gazette.*

PULMONARY CONSUMPTION AS TREATED IN THE PHILADELPHIA POLYCLINIC.

By THOMAS J. MAYS, M.D.,

Professor of diseases of the Chest in the Philadelphia Polyclinic.

If it is once properly understood that, in the vast majority of cases, pulmonary consumption is a local disease, the nature of which is a low catarrhal inflammation of the alveolar spaces, resulting from a want of physiological activity in the affect-

ed part, the treatment of this disease will become comparatively simplified. Strange to say, however, everything which is known to be capable of producing morbid phenomena in the human body has, one time or other, been held accountable for the causation of pulmonary phthisis; and it is needless to tell you that its treatment varied accordingly. Let us premise our remarks, therefore, by saying that it is a disease with an intense partiality for the apex of either lung; and the question which most naturally suggests itself is, why the apex is so susceptible to, and why the middle and lower portions of the lung surfaces are so free from it? Is this the result of chance, or is it a law with antecedents as plain as the phenomenon is regular? A correct solution of this important question will go a great way towards defining the true origin of this disease. While not at all wishing to be understood as offering an all-sufficient explanation of this difficulty, we are quite justified in holding that one of the most potent and direct causes for such a state of things lies in the manner in which the bronchial tubes enter and are arranged throughout the lungs. These structures conduct the air principally in a downward direction towards the base of the lungs—hence the lowest parts of the lungs expand first, then the middle, and, finally, towards the very end of inspiration, the apices expand, if at all. It is our firm belief, deduced from many observations, that in most persons who—like clerks, telegraph-operators, tailors, shoemakers, etc.—lead a sedentary life, and who maintain a stooped position of their chests and shoulders, the apices never become fully inflated. Another reason why the lower parts of our lungs are inflated more than the apices is because we possess nearly one-fourth more lung surface than necessary to carry on the process of respiration; and, therefore, that part of the respiratory surface which is filled with the greatest facility, viz., the base, performs the work of the whole. Therefore both the structure and the function of our lungs conspire to diminish the activity of the apices and enhance that of the bases. We have already stated, that the chief factor in the production of pulmonary consumption is a physiological inactivity of the lung apex; and if this proposition is true, then it should follow that those persons in whom the apices are least developed should be most liable to this disease, and *vice versa*.

Not long ago we made an investigation into the nature of this problem, (1) and found that the abdominal was the original type of respiration among both sexes; that the costal type of the female developed through the influence of abdominal constriction produced by clothing; that when the female falls a victim to consumption, her costal movements are markedly diminished; and that the female is less liable to consumption than

the male civilized life. It can be furthermore said that, according to Waldenburg, the vital lung capacity in persons who lead a sedentary life—such as professional men, students, clerks, etc.—is smaller than those who follow an active calling—like sailors, recruits, etc.—and it is a well-known fact that the latter class is much less susceptible to this disease than the former. And, moreover, our American Indians, who are not confined on reservations, and who are free to obey their roaming instincts, are almost entirely exempt from pulmonary consumption, presumably because of the greater lung capacity which their active life entails on them.

All these facts tend to confirm the correctness of our fundamental proposition, at least this far, that increased lung capacity decreases the liability of consumption. We think, however, when this fact is coupled with the other fact, that the civilized female possesses a much smaller lung capacity than the male, and is still less liable to the disease than the male, it is quite obvious that it is not a large chest capacity, but a well developed apex capacity which insures immunity from the disease. Barring her greater apex capacity, there is no reason, so far as we are able to discern, why the female should be more exempt from consumption than the male. Indeed, everything, both in herself and in her surroundings, tends to increase her liability in this direction. She is the weaker of the two; she undergoes the enervating processes of gestation and of lactation; she leads a sedentary and inactive life; she is occupied within doors during the greatest part of her lifetime, and is therefore constantly exposed to causes which are known to produce the disease, and most of which make the male notoriously liable if he is exposed to them.

In the next place it is important to trace the pathological relation between apex inactivity and pulmonary consumption; or, in other words, we must ascertain how such a want in development prepares the apex for the onset of this disease. You are all aware that if any organ, like a muscle, for example, does not receive adequate physical exercise, it diminishes in size; its muscular elements and connective tissue framework shrink in consequence. Precisely the same thing may happen when any part of a lung is deprived of its needed exercise—that is, when it is not expanded as fully as it ought to be during the act of inspiration—the air cells begin to shrink and collapse. The shrinkage is due to a contraction of the connective tissue around the air-cells and the small bronchial tubes, and when sufficiently pronounced it constricts the blood vessels and interferes with the free circulation of the blood in that part of the lung, and congestion and a low state of catarrhal inflammation follow as a consequence. This whole condition is analogous to that which occurs in the acquired form of atelectasy, and we would especially commend to you the remarks of Prof. Rindfleisch on the subject Atelectasia, in his

(1) An experimental inquiry into the chest movements of the Indian female.—*Therapeutic Gazette*, May, 1887.

well known work on Pathological Histology. In tracing this state of things farther, we find that the epithelial elements multiply and accumulate in the alveoli, and produce what is known as infiltration. In this way one alveolus fills up after another, until a whole group, or a cluster of them, is involved. Such an accumulation of catarrhal products exerts a decided pressure on the surrounding pulmonary and bronchial capillaries, and the blood-supply and nourishment are gradually diminished and finally cut off from these infiltrated areas, which, in due course of time, become more or less isolated and circumscribed masses, which are prone to undergo a slow process of cheesy degeneration, if the morbid process continues.

Pathologically then we have to deal here with a local infiltration of, or an accumulation of catarrhal epithelium in the air cells, brought on by physiological inactivity of the affected area, which area is, in the great majority of cases, confined to either apex. Now, what is to be done in a therapeutic way? Clearly there are here two very important indications. The first is to combat the local infiltration, and the second is to annihilate its cause. This is the method which has been pursued for some time in the hospital of this institution.

In regard to the first indication, we would say that we have here an inflammatory deposit differing, in principle, in no wise from a similar deposit in any other part of the body, and the dictates of common sense point out that that which is useful in the one condition is also useful in the other. We all know the inestimable value of counter irritation, and of passive motion in producing resorption of chronic inflammatory deposits in joints, muscular tissues, etc., as well as in the external surfaces: and in consonance with this view we apply hot flax-seed meal poultices, every day from morning until night, for a period of three or more weeks. In connection with the poultice we apply friction, iodine, etc. We are certain, from quite an extended experience, that these measures produce a powerful impression on the infiltration in question, and that they facilitate resorption more markedly than any other means at our command.

In addition to the poultices, we use local or general massage, once or twice a day, as well as electricity. In these cases of constitutional lethargy these adjuvants have the happy effect of arousing the local and general cells activity, and are usually followed by an increased appetite. In connection with all these external applications—poultices, massage and electricity—we advise our patients to take plenty of fluid food, such as milk, etc. This should not be given to the extent of satiation, but at regular intervals—say half a glass or a teacupful every hour.

So much, then, for the principal means which we believe have the power of dispersing the infiltrated catarrhal products of the lung; and what can be done in the direction of counteracting the source

of the disease? From what has already been said, it must be quite evident to you that any measure which improves the air capacity of the apices will accomplish the end in view. Among the most important measures which fulfil this indication directly are voluntary and forced breathing. The former should be practiced by taking deep and long inspirations at intervals of two hours or oftener throughout the whole day. The inspired air should be retained as long as it conveniently can be, in order to give the fullest possible expansion to the whole lung surface. The latter mode of breathing consists in inhaling compressed and exhaling into rarified air, or the reverse. This method is the most important lung expander of all. It should be begun gradually—say twice a day for a week or two, then three times for one week longer, then four times, and finally allow the patient to spend most of his time in the use of this apparatus. The great difficulty here is the limited time which the compressed air is generally employed. We are convinced that the best results follow when its use is protracted.

Physical exercise is an important indirect method by which the lungs are expanded. Under these conditions more oxygen is consumed by the muscles of the body than during rest; hence more blood flows through the lungs in a given time, and a larger lung surface is thrown into activity. Those parts of our lungs which are but rarely or never called into use now are thrown into a state of healthy expansion, and it is in this way that our whole respiratory apparatus is made to approach that condition which gives the savage, and those who pursue an active life, that freedom from consumption which we know is so common among them.

In carrying out this method of treatment, the following points should be borne in mind: first, no exercise should be carried to the extent of decided fatigue; second, whenever possible, the body and head should be erect, the shoulders thrown back, and the lungs thoroughly filled with each breath; and, third, sufficient food must be taken during the intervals. Among the most important measures to increase the lung capacity is that of pulmonary gymnastics, which should be carried out in accordance with the following directions: The arms, being used as levers, are brought as far backwards as possible, and on a level with the shoulders, during each inspiration, and brought together in front on the same level during each expiration. Another way is to bring the hands together above the head while inspiring, and gradually bring them down alongside the chest while expiring. When a deep inspiration is taken in accordance with either plan and held until the arms have gradually moved forwards or downwards, and even longer, the process of chest expansion is materially enhanced. All these movements may be facilitated by using dumb-bells or chest-weights, etc.

This, in connection with stimulant medicines

and nutritious food, has been the general line of treatment pursued, both at the hospital here and in our private practice, for some time; and we commend it to your consideration, in the full belief that you will not be disappointed in its results.—*Phil. Med. Surg. Reporter.*

THE MANAGEMENT OF THE ANTERIOR LIP OF THE UTERUS.

By DAN. MILLIKIN, M.D., Hamilton, O.

Cin. Lancet-Clinic.—I venture to remind you, in the first place, that in many obstetric cases we find the maternal parts prepared for delivery and the uterine action quite vigorous or quite intense, but in such cases can barely reach the os uteri, even by the rudest examination, with two fingers thrust far back into the concavity of the sacrum.

In such cases, if it be found possible to drag the os forward for a more perfect study of the fontanelles and sutures of the child's head, it will often be found that the labor suddenly takes on a more active character, possibly with pains quickly becoming expulsive, and with sudden dilatation of the os and softening and thinning of its margins.

When such a sequence is observed, the operator is apt to believe, as I do verily believe, that he has enabled the uterine forces to accomplish their work more efficiently and, though the hand of art has been busy, more naturally. The anterior lip then appears an impediment to labor. It is, in such cases, a sack drawn over the child's head, for you will allow me to assume for the present that there are none but head cases. This sac has a hole in it, and he appears the wisest obstetrician who pulls that hole forward and upward, with reasonable force, until he places it in relation to the prominent part of the child's head.

2. The obstetrician even of small experience will bear me out in an assertion that the anterior lip of the uterus is commonly the most resistant to those mechanical and physiological influences, which induce the softening processes which should precede the extrusion of the head from the uterus. I have no theory to offer in explanation of this fact, I only submit that it is a fact.

When this is the case, the rest of the parturient canal being ready for the rapid advance of the child, I think it is fair to say again that the anterior lip is an obstacle to parturition. What is then the remedy? How remove this obstacle?

I am not able to think of any mode of removing the obstacle, save by an imitation and acceleration of the physiological mode of softening the opposing structure; and there is no convenient method of accomplishing this result save by the same manœuvre of pulling the os forward, holding it over the most forward and prominent part of the child's head, and there retaining it with the deliberate intent to expose its margins fully and early to the tension of the advancing hand.

3. A third condition demands, it seems to me, a similar procedure. We often find on a first examination, the head well down in the pelvis, and

the posterior margins of the os wholly inaccessible to the touch, and yet the anterior lip is in such condition that it forms a thick cord just in advance of that part of the head which is ready to glide under the pubic arch. Here is a decided impediment to labor. Here is an œdema which has no more tendency to mitigate itself than has the œdema of a strangulated finger or any other pinched and bruised organ. What are we to do about it?

We have no such question to ask of the posterior lip of the uterus because the promontory of the sacrum is not adapted to produce or to maintain any such condition. There is ample room back yonder, and the posterior lip seems to be naturally more readily softened and, during labor at least, much shorter.

If the vulva is capacious, I place the tips of two or even three fingers against the œdematous cord of which I speak, with a not irrational expectation that by pressing firmly upward behind the pubis I may be able to drive out the œdema and place the anterior lip where it will no longer be pinched, but merely be attenuated and stretched in the physiological manner and by the physiological means. If the vulva is not capacious enough for this, I place the forefinger in the vagina, bend it, lay the knuckle against the cord-like anterior lip, and make the best pressure I can in that manner.

It may not be very courteous to attempt to anticipate an objection which will surely be made to this procedure—an objection to the effect that the manipulation is one which will bruise the anterior lip. The objection is good, but short-sighted. Past question, the pressure on the œdematous structure tends to bruise it; but it is already cruelly bruised, and it is eminently desirable to put it out of the way of further bruising. Moreover, its nutrition is profoundly altered by the pressure and the œdema, and, in such a case, time is an important element. Better the severe and brief than the gentler and prolonged bruising.

For three clear and readily appreciated indications, then I recommend that the margins of the os be put upon the stretch by the fingers pushing or pulling, as the case may require:

First, when the os points strongly backwards in a direction in which the child's head cannot advance; secondly, when there is a preternatural rigidity of the anterior lip out of proportion to the rigidity of the posterior lip and the general progress of labor; and, third, when there is an œdematous condition of the anterior lip due to pressure between the child's head and the mother's pubic arch.

THE QUESTION OF EXTRACTION AFTER VERSION.

N. Y. Med. Jour., Nov. 26, 1887 (Editorial):—

It is the rule of practice with many that, in transverse presentations, turning by the feet should be followed by immediate extraction. This doctrine has recently been notably supported by

Winter, on the strength of the histories of 310 transverse presentations at the maternity of the University of Berlin. Winter's propositions are: (1) Turning should not be performed until the os uteri is sufficiently dilated to admit of extraction. (2) The best results for the child will be secured when version is immediately followed by extraction.

In a recent number of the *Zeitschrift für Geburtshülfe und Gynakologie*, Dr. R. Dohrn, of Königsberg, assents to the first of these propositions, but not to the second.

Winter's second proposition, as to the time which should elapse between version and extraction, is of great practical importance. That writer reports 236 cases of turning followed by immediate extraction, the os being fully dilated, in which only 5 children were born dead, against 27 cases of turning before the os was fully dilated, the course of the labor being then left to nature, in which 13 children were born dead. These facts, he thinks, speak forcibly in favor of waiting for full dilatation and then immediately following version with extraction. To Dohrn, however, these figures are not conclusive upon the general question, for the children in the second series of cases were placed under more perilous conditions than the others, in consequence of premature interference, and better results might have been secured, in all probability, if complete dilatation had been waited for.

Dohrn believes, with Boer, that in parturition the forces of nature should be allowed full sway until there is evidence that they can no longer be trusted, that every interference for which there is no definite indication is reprehensible, and that extraction without a special cause is no exception to this rule. The results of extraction will vary with the manual dexterity of the operator and the degree of his knowledge of the mechanism of labor. This is amply shown by contrasting the two per cent. of mortality after version in Winter's statistics, the operators being skillful obstetricians attached to a great hospital, with the fifty-seven per cent. of mortality which is given as the frightful rate in general practice in the Duchy of Nassau, according to a recent report. The inference is obvious, that the natural forces were not given fair play in that locality. An important adjunction is, that in extraction the force should be exerted in the direction which the uterine contractions indicate that the fœtus is to take in any given case. In 29 cases in Dohrn's public service, in which turning was performed after the os was fully dilated, the delivery then being left to nature, there was not an accident, and he therefore infers: (1) That in transverse presentations podalic version should be performed only when the os uteri is fully dilated, although to this there may be occasional exceptions. (2) That extraction should follow immediately upon a version only when there is a well-defined indication for such a procedure; if there is no such indication, the safety of both mother and child will be most favored by awaiting delivery by the unaided natural powers.

FÆCAL ANÆMIA.

N. Y. Med. Jour., Dec. 3, 1887 (Editorial).—At a recent meeting of the Medical Society of London, Sir Andrew Clark read a notable paper entitled "Observations on the Anæmia or Chlorosis of Girls, occurring more commonly between the Advent of Menstruation and the Consummation of womanhood." Under this title the *Lancet* publishes the paper, but it more pithily expresses the view that the author took of the affection in the caption "Fæcal Anæmia" which heads its report of the discussion.

We have not space to give a summary of the argument, but must content ourselves with presenting some of the more practical aspects of the author's conclusions. The crucial test of the theory, he admits, is in the treatment, and he maintains that the treatment which most speedily and effectually cures the disease is that in which, by the use of tonic aperients, full and regularly recurring action of the bowels is produced; that with the suspension of this treatment the disease recurs, to subside again on its resumption; and that no treatment appears to be permanently successful which does not provide means for securing daily relief to the intestinal canal.

In ordinary cases he would direct the patient to sip a quarter of a pint of cold water on waking in the morning; to take a tepid sponge-bath on rising, drying herself quickly, and then being rubbed briskly with towels, to clothe herself warmly and loosely, taking care that there is no constriction of the body or of the limbs. She should have four simple, but liberal, meals, daily: Breakfast, between eight and nine, of wholemeal bread and butter, with one or two eggs, some broiled fresh fish, or the wing of a cold chicken or pheasant, and, toward the close of the meal, half a pint of equal parts of milk and tea, not infused longer than five minutes; lunch or dinner, between one and two, of fresh, tenderly dressed meat, bread, potato, some well-boiled green vegetable, and any simple farinaceous pudding or cooked fruit, preferably apple, drinking one glass of Burgundy, clear or in half a tumblerful of water; tea, between four and five, of whole-meal bread and butter, with a cup of equal parts of tea and milk; and dinner or supper, between seven and eight, resembling the mid-day meal, but smaller in quantity. Nothing is to be taken after this meal, and nothing between meals. The patient should walk at least half an hour twice a day, and as much more as her strength and convenience will allow. She should go to bed about ten o'clock, and at that time the sponging and toweling should be repeated. The bedroom should be cool and well ventilated. The patient should "lead a simple, regular, active, occupied, purposive life," and not notice or distrust herself. This seems to us an excellent regimen in the main, but we would substitute coffee for the tea.

Together with these hygienic instructions, Sir Andrew Clark prescribes an old-fashioned ferrugi-

nous cathartic, to be taken twice a day. Under this plan of treatment, nine girls out of ten recover their health in from a month to three months, and the recovery is very likely to prove permanent if they are then ordered a pill of aloes, myrrh and iron, to be taken once or twice a week in doses just sufficient to bring about a moderate natural action of the bowels.

CHLOASMA.

This is a very frequent affection, occurring upon the face, especially in women suffering from disorders of the generative apparatus. It is rare in men. The common name for it is "moth patches." The affection consists of yellowish-brown or brownish patches on various parts of the face. The forehead, chin, temples, and lower portions of the cheeks are principally affected. There is neither desquamation nor infiltration, and no subjective symptoms of any kind are present.

The causes are obscure. It is known that the discoloration appears frequently during pregnancy, to disappear after parturition. It is also a frequent accompaniment of uterine and ovarian disorders, and often disappears when these troubles are cured. The relation of cause and effect is, however, not known.

Chloasma resembles very closely tinea versicolor, a discoloration of the skin due to a vegetable parasite. The latter, however, in nearly all cases, occurs upon the chest, abdomen, arms and neck, namely upon those portions of the body covered by clothing. It is very rarely seen upon the face or hands. Chloasma, on the other hand, is almost entirely limited to the face. Tinea versicolor is slightly scaly and sometimes itches. Neither of these features are present in chloasma. Finally the latter disease occurs nearly altogether in females after the age of puberty, and generally in those who suffer from derangement of the generative organs, tinea versicolor is oftener seen in males.

The treatment of chloasma consists in removing the uterine or ovarian disease, if any can be found upon which the pigmentation depends, and in promoting the casting off of the superficial epidermal layer so as to bring a less pigmented stratum to the surface. For this purpose the applications recommended above for freckles will be found useful. The ointment or lotion of salicylic acid, or a lotion of corrosive sublimate 2.2 grains to the ounce may be used. Soft soap spread upon strips of muslin like an ointment, and allowed to remain upon the pigmented skin for several hours will produce a maceration and desquamation of the epidermis which often leaves the skin of a normal color after the redness has disappeared. The discoloration will however return unless the use of one of the ointments or lotions mentioned is continued.

The application which will give the most satisfactory results is an ointment of subnitrate of

bismuth and white precipitate, in the following combination: R.—Bismuthi subnitrat., hydrag. ammoniat., aa ʒi; vaselini, ʒi. M. ft. ungt. S: Apply to the discolorations at bed-time, and remove in the morning with Hebra's spiritus saponis kalinus.

This ointment I have used in a large number of cases with uniform success. Sometimes it is a little too active and produces irritation of the skin. Its use must then be intermitted for a few days, or the ointment made weaker. Some skins can stand a much stronger application, however, and I have used as much as two drams of each of the active ingredients to the ounce of vaseline.

The effect becomes manifest in a few days after beginning its use. There is slight scaling and roughness of the skin, showing that a furfuraceous desquamation of the epidermis is going on. In the course of ten to fifteen days the skin has become much paler, and if the application be continued the normal tint of the skin can be regained. This can, however, only be maintained by the continued use of the ointment, unless the disease of the internal organs upon which the discoloration depends has been removed.

The pigmentation of the skin from sunburn usually soon disappears after the cause has ceased acting. The bleaching can be somewhat hastened by a lotion of corrosive sublimate in emulsion of almonds (gr. j : ʒ ii).

Permanent discolorations of the skin are sometimes produced by a mustard poultice or blister. Hence care should be taken to avoid making these applications to the face, or upper part of the chest in women, as they may prove the source of an annoying or humiliating disfigurement in the latter. I have seen a number of cases in which the chest had become pigmented from mustard poultices, thus interfering with the wearing of dresses cut décolleté. To many women this is not altogether a trifling matter.

In these discolorations the use of the salicylic acid lotion above mentioned will prove useful. The prognosis must not be too sanguine, however, as the pigmentation is liable to return.—*American Medical Digest.*

STRICTURES.

Dr. McConnell believes that the only satisfactory treatment for strictures in the pendulous portion of the urethra is to cut them, and for the first three inches he prefers a bayonet-shaped tenotome. This he slips along the floor of the urethra to an inch beyond the stricture, and on drawing out the knife cuts the stricture about a line in depth, and the mucous membrane an inch before and behind it. He then enlarges the urethra by division, puts the patient to bed for several days, keeps the urine alkaline (with sodii bicarbonas gr. x, and morphinæ sulphas gr. ʒ), and afterwards passes bougies for some time.

THE VALUE OF NITROGLYCERINE IN TINNITUS AURIUM.

(Presented at the Meeting of the Otological Section in the International Medical Congress at Washington, Sept. 9th, 1887.)

By LOUIS J. LAUTENBACH, M.D., Ph.D.,

Assistant Surgeon to the Pennsylvania Eye and Ear Infirmary, Philadelphia.

After the usual experience in ear work, and a gradual accumulation of unimproving cases of tinnitus aurium, I began to study the general effects of nitroglycerine, and to use it in these cases. It had been used by others in tinnitus, both with and without success; but I knew of no way of recognizing the cases in which it would be most likely to prove serviceable. In order to learn when to use it, I began to give it in private practice to all cases of tinnitus in which I had found no improvement under other treatment, and in public practice in all cases of tinnitus. In some cases there was improvement; in others there was none.

In the patients where improvement had occurred, there was found to be present a similarity of conditions, and I soon satisfied myself that there was a class of patients in which the nitroglycerine treatment was valuable. I found it most serviceable in patients having the tinnitus aurium, without much impairment of hearing, and where but little change had occurred in the naso-pharynx, and where it was found on examination that some abnormal condition of the heart existed, either functional or organic.

In many of these cases, more or less structural changes from catarrhal inflammation of the middle ear were present; among them change in the shape and translucency of the drumhead, with accompanying change in appearance or position of the triangular light spot.

Follicular pharyngitis was present in some of the cases. The tinnitus was generally constant, or nearly so. It was not, as a rule, more marked when the patient was in a recumbent position; occasionally there was some remission in that position. The thermometric and barometric conditions of the atmosphere influenced the tinnitus. Damp weather, with low barometer, usually increased it. Dull, heavy headache more or less persistent, and most frequently located in the parietal regions, though sometimes located in the frontal region, was of frequent occurrence. In these cases I used the nitroglycerine in pill form, and in doses of one-hundredth of a grain. At first but one pill a day was given, generally in the morning. The amount given, later, was increased, enough of the pills being given to diminish the tinnitus, or to cause headache. As many as six of these pills were given in a day, though, usually, two were found to produce a beneficial effect. Improvement sometimes was manifest within a day or two after beginning the use of the remedy. In cases of long standing, the remedy was sometimes continued for a period varying from one to

three months before a satisfactory result was obtained. Cases in which there was recurrence of the tinnitus seemed to yield more readily on resuming the treatment than when the remedy was first administered. The conclusion which I reached, after a fair trial of this remedy, was that it is of value in certain cases of tinnitus aurium—especially in those where cardiac lesion exists, functional or organic, and where there is little or no loss of hearing.—*Phil. Med. Times.*

CREDÉ'S METHOD OF PLACENTAL EXPRESSION.

Although Mr. Dease, of Dublin, wrote, as early as 1783, "Should the detachment of the placenta not be effected in the usual time, it will be much facilitated by the operator judiciously applying his hand to the region of the uterus, which he may excite to the necessary contraction by gentle friction;" and although Ramsbotham, in 1839, in his text-book, condemned pulling and jerking at the cord, and advised instead gentle pressure over the uterus, it was not until 1860 that external expression of the placenta was placed on a scientific basis, chiefly by the labors of Crèdè, of Leipsic. Shortly after Crèdè's publication, the method came to be known by his name, and it has been recommended in the obstetrical books of all languages, with the notable exception of Charpentier's classical work, in which a warm protest is entered against it. Notwithstanding the general acceptance of the method, there have not been wanting those who, from time to time, have dissented from it. Whenever the criticism has seemed to call for it, Crèdè has defended his method manfully. His latest defense is directed against an attack that was made at the last meeting of German naturalists and physicians, at Wiesbaden, and is published in a recent number of the "*Archiv für Gynäkologie.*"

He discusses the objections *seriatim*. In answer to the accusation that he was guided by the watch in his procedure, he refers to his different writings, in which it is distinctly stated that the time for expressing the placenta should depend upon the circumstances of the case, and should have three different objects in view: (1) the removal of existing dangers, (2) the avoidance of threatened dangers, and (3) the saving of time. The first object calls for immediate action, as everybody agrees. To accomplish the second, an effort at placental expression should be made with the second, third, or fourth pain, but the placenta may not be expelled until the tenth pain. Usually from fifteen to thirty minutes are consumed in the process. No sane man would object to recou to some procedure to accomplish the third object provided the woman's safety was not endangered thereby. To the charge that the method is attended with increased loss of blood, he replies that accurate weighings of the blood lost—as accurate as they could have been—by different observers have not sustained the statement.

One of the most serious objections raised was that the method favored the retention of portions of the membranes in the uterus, and thus heightened the danger of septic infection. Credé denies the premise; furthermore, granting it to be true, he contests the legitimacy of the deduction with the following facts: From January 1, 1883, to March 31, 1887, 4,969 women were delivered in the Leipsic clinic and Poliklinik, without any attention being paid to retained portions of the membranes, and in not a single case did death or even severe illness ensue from such inattention. That the method requires some skill Credé does not deny; some skill is demanded in any procedure belonging to the art of medicine. The beginner must know how, and with very little practice he will acquire the necessary skill. Reliance on the action of the abdominal muscles has been recommended to supersede pressure over the uterus; but after delivery, especially in a multipara, the abdominal muscles are flaccid and incapable of powerful contraction. Stimulation of the lower part of the uterus also has been advised, but by Credé's method the whole uterus is stimulated to contraction, more especially the fundus, where the thickest muscular layers are situated. It was suggested at Wiesbaden that the body of the uterus should be drawn up over the placenta. Not only would this be contrary to nature's process, but it would involve considerable danger, inasmuch as the lower segment of the uterus is thin and easily torn. The theory that the separation of the secundines requires the accumulation of a certain amount of blood between them, and the uterine wall has but few adherents, and does not appear to be well founded. Credé favors the old view that the separation is brought about by the uterine contractions. In conclusion, he sums up as follows: His method of dealing with the placenta is in accordance with the natural process; it has been tested by experience; the objections raised against it at various times have been either unfounded or directed against phantoms; of the many recent proposed modifications of the method, some are not new, and those that are new are worthless; in short, the method stands unassailed.—*N. Y. Med. Jour.*

COLORED LIGHT IN THE TREATMENT OF THE INSANE.

Dr. Ponza, Medical Superintendent of the lunatic asylum at Alessandria (Italy), reports some experiments which he has made on the effect of colored light on lunatics. The idea was suggested to him by the observations of Robert Hunt on the favorable effect which light transmitted through violet-tinted glass on the development of animals and plants. Dr. Ponza selected rooms with as many as possible, and he has the walls painted of the same color as the window-panes. A patient suffering from melancholia, who would not eat, was placed in a room with red walls and window,

in three hours he became quite cheerful and asked for food. Another lunatic, who always kept his hands over his mouth to keep out air and nourishment, was placed in the same room, and the next day he was much better, and ate with a hearty appetite. A violent maniac was placed in a blue room, and became quiet in an hour. Another patient, after spending a whole day in a violet-colored room, was completely cured. Theoretically this appears to be a very interesting experiment, but we have good reason to believe that in practice it is of little real service. It had one very good effect, which was that it induced the medical men who were making the experiment to spend a good deal of time and attention on the patients who were under treatment. One German medical man who visited Alessandria, said it was "most excellent for the doctors." It is probable that in some future day electric light may be used for the darker parts of asylums, and then we shall be able to see whether electric light will serve to develop vitality in men as it has been proved to do in plants. In many persons of unsound mind the whole vital energy is defective, and the medical officers often feel a sad want of something which will produce energy. Stimulants of one kind or another are tried, and do some good; but we should welcome some more general natural means of improving the general health. The asylum physician looks to food, warmth, and exercise as his great assistants; and if electricity, or blue or yellow rays, can be added, so much the better.—*British Medical Journal*, March 3, 1888.

ON SCARLET FEVER AND ITS TREATMENT.

BY CLEMENT DUKES, M. D., Physician to Rugby School

Drs. Jamieson and Edington have proved that the specific cause of scarlet fever is a bacillus, which they have cultivated, and with which they have inoculated animals and produced scarlet fever. They have also shown that this bacillus occurs in the blood during the first three days of the fever; that, later on, it is absent from the blood; and that it is found most extensively in the desquamating skin after the third week. They have, further, indicated a method by which this bacillus can be destroyed in the skin, and thus the spread of the infection of scarlet fever can be minimised, and the unprotected, even when residing in the same house, be safe from falling into its rammels.

But a still more important matter is the treatment and arrest of scarlet fever in each individual; for the first cry a parent whose child has scarlet fever is, "What can you do to save my child; and how can you spare him from being maimed for life by its sequelæ?" His second question being, "How can you prevent its spreading to my other children?" This second question Drs. Jamieson and Edington have answered. It is with the hope that I may induce them to investigate the first

question that I am writing this paper; for it has already been brought within a measurable distance of being answered by Dr. Illingworth, of Accrington, who states that biniodide of mercury ($Hg I_2$) is a specific for scarlet fever. Recognizing the importance of his letter in the use of mercury as a germicide, I resolved to administer the drug at the earliest opportunity. I have now given the $Hg I_2$ in several cases of scarlet fever—with this result, that it not only arrests the fever, but it prevents the desquamation of the skin, or arrests it to such an extent that only a slight scurfiness of the skin of the hands and feet arises. If such be found to be invariably the case, will the bacilli of scarlet fever be found in the skin at all; and if not, will not the infectious period of scarlet fever be thereby reduced to a few days only, and will not the sequelæ of scarlet fever be absolutely prevented?

The $Hg I_2$ can be administered in the form of a pill or of a mixture of the liq hyd. perchloridi c. pot. iodid. The only drawback to its use which I have at present found is that if it be given before the diagnosis is absolutely certain, the physician will be apt to think, when he finds no desquamation taking place at the usual time, that the case was not one of scarlet fever. The drug prevents the desquamation of the epithelium of the tongue, as well as of the skin, and the throat rapidly heals under its use.

I was busy collecting facts when Drs. Jamieson and Edington's valuable paper, appeared, and I should have waited till I had collected a sufficient number of instances before writing this paper, had it not been for the desire that others, especially the above-named authors, would assist in establishing, or refuting, this treatment, for the experience of one individual is limited.

The benefit to be obtained from the use of $Hg I_2$ is far-reaching if it be reliable in all cases, for it not only prevents the desquamation of the skin, and thereby probably prevents the major part of the infectious nature of scarlet fever, but it will probably also be found that it obviates the necessity of keeping patients in bed for three weeks, which is the only safe rule hitherto, and isolated for five or six weeks, and will prevent the occurrence of the much-dreaded sequelæ.

The gist of the whole matter seems to be this: 1, that if the bacilli of scarlet fever are only discovered in the blood for about three days; 2, that if the bacilli, after this date, chiefly occupy the desquamating cuticle; 3, that if this desquamation can be prevented altogether by a medicine which destroys bacilli; 4, then, in all probability, the infection of scarlet fever will only last a few days; and we are within a measurable distance of limiting the spread of scarlet fever, and of removing its fangs by preventing the sequelæ.—*British Medical Journal*, July 9, 1887, p. 67.

GERMAN HOSPITAL.

Dr. Vogler presented a patient who suffered with paralysis of the left side, due to rupture of a blood-vessel in the brain. Patient was put on iodide of potassium and the fluid extract of hyoscyamus, and externally, wet cups along the spine and electricity. He has recovered motion of both limbs, arm and leg nearly normal.

Dr. Vogler presented a case of rheumatic arthritis; patient has suffered for two years with swelling and pain of upper and lower extremities, without being able to work.

He put her on large doses of salicylic acid for some days; externally, leeches, and leadwater and laudanum to allay the inflammation.

He speaks highly of an ointment composed of powdered camphor, watery extract of opium, belladonna, simple cerate, and zinc ointment. The sulphur-baths of this country or Baden-Baden and Wiesbaden of Germany, and a dry and warm climate are advised in this disease.

Dr. Deaver presented a case of shoulder-joint amputation (after Larrey's method), which he performed some weeks ago (for injuries patient sustained), with very good results.

In speaking of injuries with loss of blood, Dr. Deaver advocates hypodermic injections of alkaline solutions; if that should not be sufficient, he recommends transfusion of blood. For stimulants, he recommends the hypodermic injection of ether as the best; after that, whiskey and digitalis. Stimulants by the stomach should be given after the stomach is quiet, and they should be given in small doses at short intervals with hot drinks.

In amputations, Dr. Deaver uses the catgut for the ligaturing of the blood-vessels, hot water to stop capillary hemorrhage, and, as an aseptic, bichloride of mercury solution, 1 in 2000, to wash the parts thoroughly, and then an antiseptic dressing.

As seminal emissions usually occur after the first sleep, and are caused by the irritation of a full bladder, Dr. Sudduth gathers from this that it is well to advise patients of this character to empty the bladder immediately upon awakening in the morning, generally about 4 a.m.

BLEPHARITIS.

Prof. Keyser has excellent results from his pomade anti-blepharitic:

Oleopalmitate of lead.....	20	parts.
Almond oil.....	10	"
Simple cerate.....	5	"
Balsam of Peru.....	1	"
Liquid tar.....	½	"

Spread a cloth with this and allow it to lie on the inflamed surface each night.

FOR FETID FEET.

Since the offensive odor from certain persons' feet has been shown to be of microbic origin, Prof. Gerhard advises several applications of bichloride of mercury, 1-5000 or 1-10000.

KEITH ON HYSTERECTOMY FOR FIBROMA.

I say it deliberately, hysterectomy is an operation that has done more harm than good, and its mortality is out of all proportion to the benefits received by the few. What is the mortality of this operation, now so often and so unnecessarily performed? We shall never know. I put it at 25 per cent., though it is probably much higher. I may be wrong; others can correct me by giving their total results. In other words, one out of every four women operated on by hysterectomy has till now died after an operation for the removal of a tumor that has, as a rule, a limited active existence, and that of itself rarely shortens life. We have no right to rush our patients into such a fearful risk, yet this is done every day. In abdominal surgery responsibility seems to have become old-fashioned and gone out of date. Fortunately for those afflicted with uterine tumors, it now matters little which of the old ways of operation is the best; whether the ovaries can be removed or not, whether the extra or intra-peritoneal method be the better way of performing hysterectomy, or whether the convalescence lasts in the one case six weeks, or in the other twenty days, the treatment introduced by Dr. Apostoli must take precedence of all others. The success of this treatment is a great fact, and in saying that I accept *toto animo* his teachings, I do not speak without some experience of his practice. We have already—my son and I—in scarcely five months, applied electricity in strong, accurately-measured doses upwards of 1,200 times, in considerably more than a hundred patients, the majority in cases of uterine fibroids. The labor has not been small—indeed it has been very hard—and it is not easy to get the science of the subject into an old head. On the other hand, it has opened out a delightful study, which increases in interest every day the deeper we get into it. When I came back from my holiday in the beginning of July there were waiting for me several cases for hysterectomy, or for the removal of the ovaries for bleeding fibroids, and there have been others since. These have all gone home without operation, with menstruation almost normal, and improving after their return, with the tumors in every case reduced in size, with pain gone, and with a freedom to walk about and enjoy life such as they were long strangers to. In one case only has there been a return of hemorrhage. The tumor had gone down two-thirds, she was apparently well, and, unwilling to detain her longer in town, she was allowed to go home too soon. All were more than pleased to have escaped the risks and miseries of a surgical operation that at once put their lives in peril. We—every one of us—consider far too lightly the misery that such operations cost our patients and their friends.

Should these improvements be permanent (and we have Dr. Apostoli's word for it that if the treatment be carried out long enough such is generally the case; and, so far, I am able

to endorse almost every statement that he has made), it follows that the field for hysterectomy, for the removal of ovaries for fibroids is narrowed down to the smallest limits. I have never been in favor of hysterectomy, simply because its death rate is so high and because it is performed for the removal of a tumor that rarely kills. So strongly do I now feel on this subject that I would consider myself guilty of a criminal act were I to advise any patient to run the risk of her life—and such a risk—before having given her a fair trial to this treatment, even were I sure that the mortality would not be greater than that which hysterectomy has given me in my private cases—under 4 per cent.—*British American Journal*.

TOBACCO HEART.

Of the cases of heart disease recently treated in the writer's room, at the dispensary, nine were diagnosed as functional disorders due to the excessive use of tobacco. All the nine cases occurred in young men between the ages of seventeen and twenty-seven years.

The tobacco was used in all the cases in the form of chewing, the amount ranging from a half pound to one pound a week. The habit of chewing was begun early in life in all the cases; in one case at the age of five years; the oldest age noted at which chewing was begun was twelve years; the average was seven years.

The symptoms complained of were palpitation, pain and dyspnoea. Palpitation was present in all the nine cases and was greatest upon making any exertion. Irregular action of the heart at the time of the examination was noted in only one case. Pain was complained of in seven cases, and always had its seat immediately over the heart or under the sternum. Dyspnoea was complained of in only three cases, and was not excessive. Hypertrophy of the heart, as evidenced by increased area of cardiac dullness, was noted in two instances. In both cases the dullness extended to the right edge of the sternum. In the two cases in which hypertrophy had occurred, care was taken to exclude any other cause than tobacco. No murmurs were noted in any of the nine cases.

Treatment consisted in prescribing total abstinence from the use of tobacco, and in some cases, where this alone did not suffice, the moderate use of bromide of potassium. Notwithstanding great length of time during which tobacco had been used, and the early age at which the use had been commenced, this simple common sense treatment usually sufficed to give entire relief after three or four weeks. In only one case was digitalis used. *M. H. Fussell, M.D., University Hospital, in Periscope.*

MELANCHOLIA.

Dr. Pepper claims excellent results from hyoscine, with the ferruginous tonics, nutritious diet and complete change of the patient's surroundings.

SOAPS.

Prof. Shoemaker says that soda soaps as a rule are more irritating than potash soaps. Great caution should be exercised in the selection of a toilet soap, for in order to be entirely harmless these should have a neutral reaction. He exhibited to the class a number of principal toilet soaps, which he had gotten at different places in the city, and which he had given to an expert to be tested. With two exceptions, all these soaps contained more or less free alkali. This free alkali, he said, was, especially in young children, the cause of many skin eruptions, such as simple erythema, seborrhœa, pustular eczema, and the like.

Prof. Shoemaker then enumerated the different medicated soaps and their particular values. Alum soap is good in hyperidiosis, in pustular eczema, and in chafing. Boro-glyceride soap is useful in acne, seborrhœa, and for rough skin. Chamomile soap is mildly stimulating, excellent for bromidroses, intertrigo, and is the best soap for dandruff. Naphthal soap is the very best application for animal parasites on any part of the body, and also in bromidroses. Salicylic acid soap is a non-irritating antiseptic soap, and is good for toilet purposes. Corrosive sublimate soap is serviceable for removing freckles, chloasma, rough skin, for changing a muddy to a clear complexion, and in all kinds of itching.

DYSPEPSIA MIXTURE.

For chronic gastric catarrh, Prof. Gerhard highly recommends this *mistura dyspeptica*:

℞ Foliarum sennæ 3 ij
Pulv. rhei gr. xl
℥t. infusion with ℥iv water and add
Vini ipecacuanhæ f 3 ss
Ext. hydrastis Canadensis fld. f 3 jss
Potassii carbonatis ʒ j

Sig.—Take a dessertspoonful half an hour before eating, in water as hot as can be borne.

"VAGUE PAINS."

Prof. Atkinson considers oil of gaultheria a most valuable remedy. He gives it till ringing in the ears and vomiting occur. For a girl of seven, weak, pale, anæmic, and troubled with "vague pains," he gives

℞ Olei gaultheriæ f ʒ ij
Mucilaginis acaciæ,
Syrupi simplicis aa f ʒ iss M.

Sig.—ʒj every three hours.

In addition, he puts her on a tonic course of cod-liver oil, iron, gin, wine, and strychnia.

PROGNOSIS IN CONVULSIONS.

Convulsions following burns in small children are apt to prove fatal. I have never known a case of scarlet fever to recover in which a convulsion has occurred after the appearance of the eruption.—Prof. Atkinson.

CYSTITIS.

Dr. Parish established an artificial vesico-vaginal fistula in a woman whose urethra had been dilated three times in the past year for cystitis, probably specific, with almost constant dribbling of the urine. He claims that the hollow button, inserted between the cut edges, causes aggravation of the cystitis, and he prefers stitching them with silk, allowing the sutures to remain for at least ten days.

IN FRACTURE OF THE CLAVICLE.

Dr. White claims that the four-tailed bandage fills all the indications, if the patient can be kept in the supine posture, with the head lowered. The elbow rests in a small hole cut in the centre of the bandage, two tails, 10 inches wide, encircle the chest, and the other two, 4 inches wide, are carried round the shoulder, opposite the fracture. No pads are used.

HYOSCYAMINE FOR ASTHMA.

Dr. Musser recommends hyoscyamine, gr. 1-120 every three hours, internally; or where a rapid effect is desired, gr. 1-140 to 1-120 hypodermically; for the spasmodic asthma of emphysema. He uses, in addition, nux vomica as a respiratory stimulant, and terebene or oil of eucalyptus for the accompanying bronchitis, diminishing the hyoscyamine as the other drugs are increased.

IRITIS.

Prof. Keyser at once gives gr. 1-12 bin-iodide of mercury, with gr. v iodide of potassium, three times a day, and applies hot stupes of hamamelis for the pain. If no benefit be noticed in three or four days, he drops the mercury and tries salicylic acid gr. xx ter die. If a condyloma is detected on the iris, he is sure of specific cause.

BROMINE IN CROUP.

Prof. Howell has known of a number of instances in which a drop of bromine, with each dose of bromide of potassium, acted well in throwing off the membrane in croup.

FLATULENCE DUE TO FERMENTATION.

In a case of windy dyspepsia, due to indigestion of starches, Prof. Waugh simply prescribed diastase, with excellent results.

In the case of a child seventeen months old, very low with marasmus, accompanied by diarrhœa and vomiting, Prof. Waugh stopped its milk and substituted predigested food. The vomiting and diarrhœa he treated by sulphocarbonate of zinc, gr. ¼ every two hours. The child is improving rapidly.

THE CANADA MEDICAL RECORD.

A Monthly Journal of Medicine and Surgery.

EDITORS :

FRANCIS W. CAMPBELL, M.A., M.D., L.R.C.P. LOND.
Editor and Proprietor.

R. A. KENNEDY, M.A., M.D., Managing Editor.

ASSISTANT EDITOR :

A. LAPHORN SMITH, B.A., M.D., M.R.C.S. Eng., F.O.S.,
LONDON.

— — —
SUBSCRIPTION TWO DOLLARS PER ANNUM.
— — —

All communications and Exchanges must be addressed to the Editors, Drurver 356, Post Office, Montreal.

MONTREAL, MARCH, 1888.

PROFESSIONAL SUCCESS.

We commend to the attention of our readers the excellent advice to the graduates of the valedictorian for the Faculty in another column, on the subject of professional etiquette. Indeed, we consider this subject of so much importance, that we purpose devoting a column of our pages every month to the reproduction of the code of ethics of the American Medical Association.

On reflection, it will be evident to every one that it is to the advantage of the profession, both as a whole and as individual members, that all our dealings with each other and with the public should be of the most honorable nature. Nothing ends to lower us so much in the eyes of the public as the little backbitings and petty jealousies which we unfortunately too often see, and which are turned to the disadvantage of the backbiter quite as much as to that of the one detracted. Even if something disparaging is said about us by a brother, no matter how great the provocation may be, and no matter how much we may be tempted to retaliate, it will prove better in the long run to take no notice of such injustice, feeling certain that in the end truth and right must prevail. If we see a brother succeeding a little better than ourselves, let not this excite our jealousy or wrath, but rather our emulation; for we may be sure that he possesses some little qualities which we do not. Instead of wasting our time in finding fault with him for succeeding, rather let us find out what those qualities are and cultivate them. * In nine cases out of ten

we may acquire them as well, and turn them to the same advantage as he has turned them.

Although fortune may occasionally help a man to a high position, no power on earth can make a man fill a position for which he is not fit. The highest and most enduring reputations in the profession have been those which were made slowly and laboriously, because they were built on a sure foundation. And it is a rule, to which there are but few exceptions, that we are sure to attain just that position for which we are fit, and no higher; consequently hard work is the only sure road to success. In the practice of medicine as in the evolution of nature, the fittest will survive.

LONGEVITY AND MEDICAL MEN.

In an excellent article in the "19th Century," Dr. Burney Yeo points out the causes which lead to a long life. He obtains his data by analyzing the lives of those who have reached a great age and whose mode of living was well known. He finds that the most important thing is to obtain a regular and sufficient amount of sleep. The number of hours required is greater than most men get, being over rather than under eight hours. The truth of the adage "early to bed, etc.," is fully borne out by his statistics. The second requirement in importance is to have one's meals at regular hours, and to have sufficient time to eat them properly. The third advantage is to have a mind free from care and worry. And the fourth to have plenty of exercise in the open air. Although several centenarians were in the habit of using during a considerable part of their lives wine and malt liquors, still the majority were either total abstainers or exceedingly abstemious.

From the consideration of these facts, it is not surprising to find that the average death rate of medical men is double that of clergymen. Is there anywhere a medical man who takes plenty of time to his meals, who gets more than eight hours of sleep, who is free from anxiety, or who gets sufficient exercise in the open air?

Although many of these adverse conditions are absolutely inherent to a doctor's life, still there are some of them which might, with a little trouble, be considerably ameliorated. Take, for instance, night work; laying aside cases of midwifery, the majority of times a doctor is sent for at night are for cases which should have been seen to during the day, or even the day before. People have fallen so into the way of thinking of the doctor as a kind

of night owl, who delights in prowling about in the darkness, that they forget that he is only human, and needs unbroken sleep as much or even more than any other worker; indeed, we know of cases in the country where they send for the doctor at night, simply because it suits their convenience to go for him after the day's work is done, and because they are too busy to send for him in the day time. The victims of this thoughtlessness of course broke down in health, and had to give up practice altogether for nearly a year, for which loss they received no compensation. There is a way to avoid this common cause of loss of health and early death, and that is by educating the people, especially one's own patients, to understand that a doctor requires rest as much and more than any one else. How are we to do this? By refusing to go out at night? No. By evincing anger? No. How, then? Simply by charging double or triple for night visits. Let us get up and go with the messenger with alacrity, and even the appearance of pleasure if we can, but wait until we send our bill, and then remember to make the difference between the charge for night visits and day visits so strikingly great, that even the dullest patient cannot fail to observe it. Nor need we fear to loose any, or at all events many, patients by following this course. They will soon get to understand that it is for their good as well as the doctor's that they should send for him in the day-time.

DOCTORS' BILLS.

In the article referred to above, another cause of shortened life is financial worry, or what might be expressed by the words "being hard up." Whether medical men are ever in this condition we cannot state; but if they are, it is not to be wondered at, when we remember how negligent they are in business matters, but more especially in sending out and collecting their accounts. It is a general complaint among medical men that to one likes to pay the doctor's bill. That the same person who pays his grocer and butcher gladly and promptly is slow in paying the medical adviser, to whom, perhaps, he owes his life. And we are apt to say that our patients are ungrateful. But we think medical men are themselves to blame. It is too much to expect of human nature that our patient's gratitude will keep as fresh after many months as it was the very day we pronounced him out of danger. The present system of sending out accounts once a year is altogether wrong.

Even the patients themselves frequently ask many times for their accounts before they can get them, and it is only after they have forgotten all about them that the bills come in, perhaps when they have spent the money on something else. If doctors would spend a few hours on the last day of every month, they could send out bills for services rendered during the month, as well as reminders, in the form of a second account, to those who have forgotten to respond to the first one. We have followed this method in our own practice, and do not think we have ever lost any patients thereby, except a few of that undesirable class, who, though quite able, never have any intention of remunerating the physician for his services. In fact, this is one of the advantages of this system; it soon lets you know who intends to pay and who does not. Indeed we know of some specialists in this city who send a bill to a patient on the first day of the month, who only came for his first consultation on the thirtieth on purpose to let him know what his charges were. Be it understood, however, that in these remarks we are only referring to the doctor's right to be paid by those who are quite able to do so; we do not wish to discourage any one from attending all poor people free of any charge.

We may have something further to say on the subject of fees in our next issue, as this is always a subject for discussion among medical men.

THE CODE OF ETHICS OF THE AMERICAN MEDICAL ASSOCIATION.

OF THE DUTIES OF PHYSICIANS TO THEIR PATIENTS
AND THE OBLIGATIONS OF PATIENTS TO THEIR
PHYSICIANS.

ART. I.—*Duties of Physicians to their patients.*

1. A physician should not only be ever ready to obey the calls of the sick, but his mind ought also to be imbued with the greatness of his mission, and the responsibility he habitually incurs in its discharge. These obligations are the more deep and enduring, because there is no tribunal other than his own conscience to adjudge penalties for carelessness or neglect. Physicians should, therefore, minister to the sick with due impressions of the importance of their office; reflecting that the case, the health, and the lives of those committed to their charge depend on their skill, attention and fidelity. They should study, also, in their deportment, so to unite *tenderness* with *firmness*,

and *condescension* with *authority*, as to inspire the minds of their patients with gratitude, respect and confidence.

2. Every case committed to the charge of a physician should be treated with attention, steadiness and humanity. Reasonable indulgence should be granted to the mental imbecility and caprices of the sick. Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed; and the familiar and confidential intercourse to which physicians are admitted in their professional visits should be used with discretion, and with the most scrupulous regard to fidelity and honor. The obligation of secrecy extends beyond the period of professional services; none of the privacies of personal and domestic life, no infirmity of disposition or flaw of character observed during professional attendance should ever be divulged by the physician, except when he is imperatively required to do so. The force and necessity of his obligation are indeed so great, that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice.

3. Frequent visits to the sick are in general requisite, since they enable the physician to arrive to a more perfect knowledge of the disease—to meet promptly every change which may occur, and also tend to preserve the confidence of the patient. But unnecessary visits are to be avoided, as they give useless anxiety to the patient, tend to diminish the authority of the physician, and render him liable to be suspected of interested motives.

4. A physician should not be forward to make gloomy prognostications, because they savor of empiricism, by magnifying the importance of his services in the treatment or cure of the disease. But he should not fail, on proper occasions, to give to the friends of the patient timely notice of danger when it really occurs, and even to the patient himself, if absolutely necessary. This office, however, is so peculiarly alarming when executed by him, that it ought to be declined whenever it can be assigned to any other person of sufficient judgment and delicacy. For the physician should be the minister of hope and comfort to the sick; that, by such cordials to the drooping spirit, he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned in their last moments. The life of a sick person can be shortened not only by the

acts but also by the words or the manner of a physician. It is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress to his spirits.

5. A physician ought not to abandon a patient because the case is deemed incurable; for his attendance may continue to be highly useful to the patient and comforting to the relatives around him, even in the last period of a fatal malady, by alleviating pain and other symptoms, and by soothing mental anguish. To decline attendance, under such circumstances, would be sacrificing to fanciful delicacy and mistaken liberality, that moral duty which is independent of, and far superior to, all pecuniary consideration.

6. Consultations should be promoted in difficult or protracted cases, as they give rise to confidence, energy and more enlarged views in practice.

7. The opportunity which a physician not unfrequently enjoys of promoting and strengthening the good resolutions of his patients, suffering under the consequences of vicious conduct, ought never to be neglected. His counsels, or even remonstrances, will give satisfaction, not offense, if they be proffered with politeness, and evince a genuine love of virtue, accompanied by a sincere interest in the welfare of the person to whom they are addressed.

PERSONAL.

Our readers will regret to learn of the illness in London of our young confrère, Dr. Rollo Campbell, his father, Dr. F. W. Campbell, being summoned to England to attend him. From advices received to-day however, we are glad to learn that his illness is not of a dangerous nature, being simply nervous exhaustion from overwork in preparing for and passing the first half of the examination for the M. R. C. P., London, in which he has been successful. He has been advised to defer the passing of the other half until his health is better, but with the determination which is hereditary he is already hard at work again.

Dr. J. B. Howard and wife have sailed for a prolonged visit to Europe. We are glad to learn that with good care she has completely recovered her health.

The wife of Dr. G. T. Ross has presented him with a daughter.