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Original Communications.

TYPHLITIS AND APPENDICITIS.*

BY WILLIAM OSLER, M.D., F.R.C.P. LOND.

Professor of Clinical Medicine in the University of Pennsylvania.

Cæcal and peri-cæcal inflammations are described under the various terms typhlitis, peri-typhlitis, para-typhlitis, peri-cæcal abscess, and appendicitis. I think we may clinically, and for practical purposes, distinguish two groups of cases, to the first of which the name *typhlitis* may be restricted, and to the second *appendicitis*, or, perhaps, better, as Dr. Fitz suggests, *perforative appendicitis*.

Typhlitis.—By this we understand inflammation of the cæcum. The term has also been used to designate inflammation of the contiguous parts as well; but it may be limited to the cases in which the caput cæci and the adjacent portion of the ascending colon are involved. Unfortunately, we know nothing of the anatomical condition described under this term. I have myself never seen a post-mortem, nor do I know of a report in which the disease was confined strictly to the walls of the intestine in these regions.

The cases are commonly met with in young persons, particularly in young males. The attacks are very often associated with errors in diet. In the majority of cases there is a history of constipation. The symptoms are very distinctive. The patient complains of pain in the right iliac fossa; there is constipation and often nausea—sometimes vomiting. At first there may be no fever, but subsequently the temperature rises from 100° to 102°. On examination, the patient is usually found with the right thigh flexed on the abdomen. There is slight fullness in the right iliac fossa; tenderness on pressure, and, often, dullness on percussion. In the majority of instances there is distinct induration, which may have a rounded outline, so that the expression "sausage-shaped tumor" has been applied to the condition. Such cases are extremely common, and are usually regarded (no doubt properly) as the result of fæcal impaction — typhlitis stercoralis. With proper treatment, recovery is the rule. Local applications—the ice-bag, turpentine stupes—are usually found sufficient to allay pain. To break up the fæcal masses, large injections should be used. Purgatives may be administered, but I prefer, as a rule, to rely on large injections.

Attacks of this kind may repeatedly occur in the same patient; I have known of four or five recurrences within four years. There can be very little doubt that this local inflammation is due to fæcal impaction. The inflammation is confined to the intestinal wall, and rarely extends to the tissues in the neighborhood. It is true, that occasionally there may be more serious disease of the cæcal coats. I have put on record two instances of round ulcer of the cæcum, in both of which perforation occurred, with the production of peri-cæcal abscess. It is quite possible, of course, that inflammation may extend to the loose connective tissue behind the cæcum—when that organ is attached—and even go on to suppuration. But, with the exception of the cases of ulceration, I have no personal knowledge of instances in which there has been peri-cæcal abscess apart from disease of the appendix.

The opinion has been expressed, and is I believe widely held, that the cases such as I have here described are also in reality due to appendix disease; that typhlitis and peri-typhlitis mean in all cases tubal affection. I confess there is often great doubt as to the true nature of a case, but, clinically, I believe we can recognize a stercoral typhlitis. There is at present in my wards at the Philadelphia Hospital a case in illustration. Lad, æt. 22, admitted 22nd, with temperature of 102°, a furred tongue, constipation and abdominal pain. On examination, there was tenderness in the right iliac fossa, the thigh was drawn up and everted; the right iliac region was dull, tender to the touch, and presented a distinct induration, without definite outlines. He had nausea and vomiting on

* The substance of remarks made at the Toronto Medical Society, December 26, 1888.

admission. Stupes and poultices were applied, and large enemata were given; no opium, as the pain was not excessive. The injections brought away a number of hard fæcal masses. The temperature on the third day was normal, the induration and tenderness gradually disappeared, and on the sixth day the sense of resistance in the two sides was equal, and the patient said that he felt quite well. He had had a similar attack six weeks before. Such cases we have all seen, and whatever the morbid condition may be, I think they possess features which separate them from the next group.

Appendicitis.—In the second group of cases the lesion proceeds from the appendix vermiformis, which is liable to various affections—catarrhal inflammation, catarrhal ulceration, obliteration, obliteration of the proximal end, dilatation of the tube, and perforation. Foreign bodies may also lodge in it, and fæces moulded to the tube may become hardened and calcified so as to form small enteroliths.

In a recent report (*Med. and Surg. Rep.*, Oct. 6th, 1888) I gave notes of eleven cases in which I had met with ulcers in the appendix, usually in connection with phthisis or typhoid fever. I have never met with foreign bodies in the appendix. On one occasion five apple pips were brought to me as having been found in, and removed from the tube, in a dissecting-room subject; and in one of the cases in the post-mortem books of the Montreal General Hospital, Dr. Sutherland (who was acting as Pathologist in my absence) records the presence of six or eight snipe shot in the appendix of a man dead from Bright's disease. The resemblance of the small enteroliths to date-stones, frequently leads to error.

Inflammation and ulceration of the appendix vermiformis (so long as it is confined to this tube) may produce no definite symptoms. There may be the most extensive ulceration, the lumen may be completely obliterated, there may be extreme distention, without the patient manifesting any signs of abdominal disorder.

If the appendix is quite free, it is possible that ulceration may go on to perforation, without the tube forming attachments. This, however, is very exceptional. More commonly adhesions form and the perforation leads to localized abscess, the situation of which will depend upon the position of this extremely variable structure. It is most commonly situated in the right iliac fossa, and is either within the peritoneum, when the appendix is entirely surrounded by this membrane, or it is behind the peritoneum, when the appendix (which is rarely the case) has only a partial serous covering. I have seen perforation occur with the formation of localized abscess, within the pelvis in the neighborhood of the broad ligament; in another instance immediately upon the sacrum, the tip of the appendix lying to the left of the middle line; and, in a third instance, the abscess was high up behind the mesentery upon the psoas muscle.

I do not think that sufficient stress has been laid upon the fact, that this local inflammatory process almost invariably precedes the graver manifestations. That healing may take place at this stage, is shown by the occurrence of an obliterated tube closely adherent with fibroid thickening and much pigmentation of the surrounding tissue. Once perforation has occurred with abscess formation, the course is extremely variable. It is within the experience of almost every physician to have seen the pus appear anteriorly in the neighborhood of the groin, where it may open spontaneously. The presence of gas, or even small fragments of fæces, may show that there is open communication with the bowel. Two such cases I saw with my preceptor, Dr. Holford Walker, of Dundas, in 1868 and 1869. One of these cases made a good recovery; the other, with much more extensive abscess formation and perforation in several places (through which gas discharged), succumbed to septic fever. That the tube of the appendix is not always obliterated at its cæcal end before perforation occurs, as is claimed by some writers, is shown by such cases. The pus may burrow and appear in the lumbar region, or it may pass down and appear in the peritoneum and form a peri-rectal abscess. A more favorable event is, when the abscess perforates into a neighboring viscus—the colon, the cæcum, the rectum or the bladder. In a recent report of a case in a French Journal, in which the abscess perforated into the bowel, the characteristic oval enterolith was found with the discharged pus and fæces. Perforation into the bladder is less common. At the Montreal General Hospital, in the Summer session of 1882, I lectured upon two cases in which this event occurred with recovery. I met with a curious sequel in a case

of peri-cæcal abscess which perforated into the bowels. The patient had for some years after, and may still have for aught I know, persistent enlargement of the right leg, due, undoubtedly, to chronic venous stasis consequent upon the narrowing of, or perhaps the obliteration, of some of the large veins in the pelvis. A third and almost necessarily fatal mode of termination, is when the local circumscribed abscess perforates the peritoneum, setting up a diffuse, virulent and septic inflammation.

I have never yet seen instances of perforative appendicitis in which there were not attempts made to limit the inflammation. Even when the appendix has been free in the peritoneum, walls circumscribing the abscess are formed by the adherent mesentery, retro-peritoneum and intestinal wall. Symptoms of perforative appendicitis are fairly well defined. A number of cases begin with intestinal trouble, constipation or pain in the iliocæcal region, lasting for a variable time. A more characteristic mode of onset is a sudden, sharp pain in the right iliac fossa. This may be followed by collapse symptoms, or more usually by an aggravation of the intestinal disturbance. It is worth noting, that strain, such as sudden lifting or jumping, may be followed by an acute pain, and may, apparently, be the starting-point of appendicitis. The local symptoms are rarely as well marked as in typhlitis Tenderness is usually present; there may be fullness, or even induration, but in my experience, these signs are more frequently absent. The leg is usually drawn up, thereby relaxing the psoas muscle. Irritability of the bladder, as shown by frequent micturition, not infrequently occurs. The fever is moderate; the tongue is furred, but constipation is not so constant a feature as in stercoral typhlitis. Abdominal distention (tympanites) comes on early, and may interfere with proper examination. A rectal examination may indicate fullness towards the roof of the pelvis, but unless the whole hand is used, the ordinary digital exploration is practically worthless. Practice on the cadaver, with the pelvis exposed, shows how futile is the attempt to reach, even with the longest finger, those higher portions of the pelvis which the peri-cæcal inflammation usually affects. Increasing tympanites, diffuse tenderness on palpation, aggravated constitutional symptoms, indicate the spread of the peritonitis. It must not be forgotten that the peritonitis may be limited to the lower portion of the abdomen, even confined to the coils of the small intestines situated within the pelvis. Such abdominal distention may be extremely slight. I saw, with Dr. Musser, last year, a case of perforation of the appendix with peritonitis, in which the abdominal walls were flat and presented a hard, board-like resistance to palpation.

In a considerable majority of cases, I think the sudden onset with sharp intense pain, indicates, not the perforation of the appendix, but the extension of an already existing inflammatory process. As I have stated, extensive ulceration, distention, adhesion and obliteration of the tube, may occur in persons in whose history there is no account of localized abdominal inflammation. It is not impossible that ulceration, leading to perforation and local abscess, may occur without exciting severe symptoms. I have so often seen, about the perforated appendix, signs of chronic inflammatory mischief indicated by fibrous bands and pigmentation, that the process has certainly ante-dated the onset of the acute fatal illness of only a few days' duration. Marked tendency to recurrence finds also its explanation here, in the temporary aggravation of the condition. Surgeons have repeatedly, in these cases of recurring attacks in the peri-cæcal region, cut down and removed an adherent, chronically inflamed and even perforated appendix.

In many instances the diagnosis of perforated appendix presents great difficulties. Perhaps, of all the symptoms, the most important is the sudden agonizing pain occurring either at first, or after gastro-intestinal symptoms have lasted for some days. Its importance may be gathered from the fact, that of 257 cases analyzed by Fitz, it was present in 216. Abdominal pain and distention are more marked, and occur earlier than in ordinary typhlitis. Induration in the iliac fossa is also less common; indeed, a very considerable proportion of the cases present no local tumor. The diagnosis in such cases rests largely upon the mode of onset, the development of symptoms, the previous history of the patient, the absence of signs of hernia or of internal strangulation. The occurrence of frequent micturition and the characteristic decubitus of the patient, are highly suggestive symptoms. Cases occur in which it seems impossible to accurately determine the condition, and the patient

presents the picture of general peritonitis, which has started from some unknown locality.

Treatment of peri-cæcal abscess from appendix disease has made great progress within the past few years, and the operation devised by Willard Parker has now become, not only a very frequent, but a most successful one. As I have already stated, there are many instances of spontaneous recovery, even when extensive suppuration has occurred. We all have seen, in the recurring attacks of this disease, the gravest symptoms disappear and the patient rapidly convalesce. The medical treatment is much the same as I have spoken of in typhlitis. Opium, in some form, has almost always to be used to relieve pain. For constipation, large injections may be employed. In the early stage I never use purgatives. I would hesitate to employ even a saline cathartic, which moves the bowels with very little disturbance of the peristalsis. Not that I would hesitate when general peritonitis is established, as I believe this method of treatment to be in a high degree rational. A concentrated saline purge produces local depletion of the intestinal vessels from duodenum to cæcum, and removes in great part the interstitial œdema of the intestinal wall upon which, chiefly, the paralysis depends. But, in the early stages of the affection, our means should be directed towards limiting the inflammatory process, and favoring those conservative barriers which nature invariably sets up against extending inflammation. I have been so much impressed with the fact, that in these cases the dangerous symptoms seem to originate by the extension of the disease from a localized peri-cæcal abscess—the walls of which may be in part mesenteric, or, as I have seen, intestinal—that I dread the disturbing influence of purges. The indications for surgical interference are not always clear; but my experience has taught me that the abdomen is much more frequently left untouched than it should be, and that an operation is too often deferred until practically useless. Local indications may be very positive, particularly when the perforated appendix lies behind the peritoneum, in the iliac fossa spine above Poupart's ligament. But when the abscess is high on the psoas muscle, or lies within the brim of the pelvis, or far over towards the middle line, these symptoms are absent, and in such cases, from the general condition alone, the indications for operation must be gathered. We may say, as a general rule, that in young persons, in whom the attack has set in with severe pain in the right iliac fossa (whether preceded or not by previous digestive disturbance), and in whom the constitutional symptoms, as shown by rapid pulse, fever and coated tongue, indicate a serious lesion—when tympanites and abdominal tenderness exist, it is better in these days of safe laparotomy to give the patient the benefit of any diagnostic doubt, even without the existence of local tumor, and to explore thoroughly the peri-cæcal region. Still more urgent would such indications be, if the patient had had previous, though less severe attacks.

PAIN IN EYE DISEASES.*

BY A. B. OSBORNE, M.D.,

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In the following paper I shall endeavor briefly to review some time-worn facts familiar to all, but presented in an order probably more familiar to the specialist than the general practitioner, and I hope in presenting the well-known painful symptoms in Eye Disease, viewed from a diagnostic standpoint, that it may prove of interest to the busy physician.

The eye is such a perfectly accessible organ, and the examination—not only of the exterior, but also of the contents and interior of it—can be made with such facility, that we are apt to rely too much upon purely objective symptoms for the basis of our diagnosis. To do justice to the eye under examination, due attention should be paid to the subjective, as well as the objective signs, and the most important subjective symptom is pain. In no other part of the body does the patient describe his sufferings more graphically, or localize them more correctly; and we ignore an important factor in the formation of a correct diagnosis, when we pay little heed to his careful description.

The only sensory nerve of the eye and its appendages is the fifth, which supplies the conjunctiva, cornea, and lachrymal gland, and, through its long ciliary branches, the iris and ciliary body: so

* Read before the Hamilton Medical and Surgical Society, February 5th, 1889.

that all pain must be made evident through the branches of the fifth nerve. Pain in the eye, as in other portions of the body, is either inflammatory or non-inflammatory, and inflammation of any of the structures of the anterior portion of the eye is accompanied by pain, thereby differing from inflammations of the lining membranes and contents.

In *Conjunctivitis*, although the nature of the disease is evident at a glance, the character of the pain is distinctive—a feeling of smarting and dryness, itching and sensations of sand in the eye; occasionally the nerve branch supplying the lachrymal gland partakes in the irritation, causing a copious flow of tears. The patient describes this pain accurately and localizes it correctly, indeed he not infrequently indicates the exact point upon the palpebral conjunctiva at which a foreign body is situated.

Episcleritis is not usually characterized by pain, but it may occur owing to a secondary compression of the ciliary nerves by the inflammatory exudation.

The pain accompanying *Ulceration of the Cornea* is, as a rule, acute, and referred to the ciliary region. Associated with this pain there is frequently Photophobia, in the production of which a curious reflex occurs. When the light falls upon the retina, there follows a painful blinding sensation, accompanied by an incontrollable impulse to close the eyes. The point to be observed is, that the pain is not caused by the light irritating the inflamed cornea, but by light falling upon the uninjured retina. The optic being a nerve of special sense and almost, if not entirely, devoid of common sensation, it is evident that, for the production of this reflex, the irritation must be transferred to the sensory nerve of the eye—the fifth; probably the same chain is concerned in the reflex sneezing which occurs in some persons when passing suddenly from dim into bright glaring sunlight. It is possible that there is a sufficiently intimate connection between the optic and fifth nerves in the retina, to allow the transference to take place there. Photophobia is a valuable symptom, as it usually indicates that the cornea has become affected.

In *Iritis* there is acute suffering. The pain is felt in the eyeball and radiating over the regions supplied by the supra and infra-orbital branches of the fifth, and sometimes along the side of the nose. It is very intense in character, worse at night and early in the morning. In this affection there is pain when the eye is exposed to light, but it differs from that of photophobia in being direct and not reflex, the inflamed and painful iris contracting when the light falls upon the retina and so causing the pain directly. Iritis may be accompanied by photophobia also. When iritis is accompanied by tenderness to the touch, we know that the ciliary body has become involved in the inflammation—a condition known as *Irido-cyclitis;* the degree of tenderness being a good gauge of the severity of the process. The only other affections giving rise to tenderness on pressure are glaucoma and neuralgia, and in these the tenderness is neither constantly found, nor is it confined to the points of contact.

Acute Inflammatory Glaucoma gives rise to severe pain in the eye, occurring chiefly when the head is congested. There may also be acute pain in the bones forming the orbit. Accompanying the pain there is inflammation and chemosis of the conjunctiva, with subconjunctival injection Chemosis and tumefaction of the lids also occur in severe cases. The pain in the eyeball is owing to the stretching of the ciliary nerves, due to the increase in the contents of the eye, and to this stretching of the nerves is to be ascribed the dilatation and immobility of the pupil, as well as the anæsthetic condition of the cornea. Coincident with the onset of acute glaucoma, there is usually some febrile disturbance, with increased rapidity of the pulse and vomiting. In this connection it may be well to remind you of the fact, that atropine will induce glaucoma in an eye predisposed to it, and the application of atropine to an eye already suffering from this affection will materially assist the progress of the disease.

In *Suppurative Choroiditis*, which involves the entire uveal tract, the pain is indescribable and the ball exquisitely sensitive to the touch.

The ordinary choroidal and retinal inflammations are unaccompanied by pain, so also with affections of the vitreous humor and optic nerve.

Tenderness in a shrunken eyeball indicates inflammatory action involving the remains of the ciliary nerves, and is an indication for its removal, to avoid sympathetic inflammation in the sound eye.

Intra-ocular tumors, especially sarcomata, occasionally give rise to aching pain.

From the foregoing it will be seen that pain—almost pathognomonic in character—usually accompanies inflammatory affections of the anterior half of the eyeball.

Non-inflammatory pain, so-called, occurs in neuralgia, glaucoma, errors of refraction, and cases in which there is defective action of the motor apparatus, and in asthenopia.

Neuralgia of the eyeball is most frequently found in persons who are subject to neuralgic pains in the head, especially affecting the fifth nerve. The pain is intermittent, may be accompanied by tenderness to the touch, the pupil remains active, usually only one eye is affected, and there are no ophthalmoscopic symptoms.

Glaucoma Simplex, or chronic non-inflammatory glaucoma, may be accompanied by a constant aching pain, with a sense of fulness in the eye, or the pain may be referred to the brows. There is no evidence of inflammation, and the pain is by no means a constant symptom. Of course the characteristic symptoms of glaucoma serve to distinguish this affection from the others on the non-inflammatory list.

The pain experienced in cases in which there is an *Error of Refraction*, and that which occurs with defective action or innervation of the motor apparatus, is very similar, and due to the same cause, viz., a want of proper relation between the amounts of convergence and accommodation brought into play This form of suffering is familiar to all who have strained their eyes over small type, or read too much in a bad illumination; it consists of a dull, sickening, frontal headache, with a tired feeling in the eyes, or the pain may be diffused through the head. Where the convergence is principally at fault, giddiness may be added to the other symptoms. There is frequently an irritable condition of the conjunctiva, accompanied by blepharitis in hypermetropes, which yields almost immediately when the normal relation between convergence and accommodation is restored by suitable glasses.

The term *Asthenopia* has long been to the ophthalmologist what Debility was to the general practitioner, viz., a harbor of refuge in a sea of doubt. True, every year reduces the number of cases in which we require to generalize in this way; but it is also true, that we are still obliged to evade certain difficulties by resorting to vagueness. That there is a form of neurosis which may safely be termed *Retinal Asthenopia*, is a fact familiar to all eye surgeons, and in these cases the symptoms are entirely subjective. Pain is complained of at the back of the eyes, and it may be very severe, occurring after using the eyes for near work; accompanying the pain there is usually extreme sensitiveness to light. Mr. Gunn describes a condition of the retina in these cases, to which he has applied the term "Crick Dots"; but the detection of this anomaly is a refinement of ophthalmoscopy which few may hope to attain to.

A second form of asthenopia appears to be due to a certain existing—but difficult to demonstrate—weakness of the ciliary muscle; it is most frequently found among debilitated women who require to sew a great deal. Another form of asthenopia is referred to hyperæsthesia of the optic centres. Unfortunately, in the present state of our knowledge, it is not easy to indicate in each case the region which is at fault.

Correspondence.

OUR NEW YORK REPORT.

From our own Correspondent.

NEW YORK, Feb. 19th.

A FEW POINTS ON PHTHISIS, PICKED UP AT THE CLINICS AND LECTURES OF 1888.

ETIOLOGY.

Here the sole exciting cause of phthisis is believed to be the tubercle bacillus; this theory is accepted as proven beyond the shadow of a doubt.

DIAGNOSIS.

In reading many of the standard authors of the day, the practitioner and student are directed to look for the earliest signs of phthisis at the apices of the lungs in front, and much stress is laid on careful physical examination of that portion of the lungs situated just below the clavicle. That this view is erroneous is not generally recognized, hence the failure of many physicians to make a diagnosis of incipient phthisis. The regions that the New York physical diagnosticians lay special stress on to examine, are the scapular and supra-scapular, posteriorly; and Prof. Loomis states that much of his success in his earlier days was due to this

one fact, and he has again and again made the diagnosis of phthisis by careful examination of these regions, where competent men had failed to observe the early changes in the lung tissue, for the simple reason that they had confined their examination to the infra-clavicular regions.

Here it is that we should listen for the prolonged high-pitched breathing which is so significant, and if it is accompanied by râles on coughing, the diagnosis is almost certain. The slight dulness on percussion as compared with the opposite side, is considered of very little value; in the first place, it takes an experienced person to make it out, and by the time it can be distinctly appreciated, the chances are that the phthisical processes have advanced to the second stage. Auscultation, then, is the principal method of examination, for the reason that it is so much more delicate than percussion; and the early changes can only be appreciated by auscultation, not by percussion. Whisper resonance is much more used, for the same reason. In passing, it might be stated, that in all pulmonary examinations the posterior aspect of the chest is the one which is regarded as important, and in many instances the anterior is neglected altogether; many cases of well marked pneumonia give absolutely negative results in front, while behind all the signs of an extensive pneumonia can be distinctly appreciated. From this it is not to be imagined that only the posterior portion and apices of the lungs are to be examined; the rule is to explore every portion of the chest thoroughly, as I have seen several well marked cases of phthisis which originated in the bases of the lungs. The use of the stethoscope for the diagnosis of pulmonary diseases is almost entirely discarded in New York, and the ear substituted in place of it; in cardiac diseases it still holds sway. The much disputed question as to the seat of production of the crackling sounds and crepitant râles heard in phthisis, whether they are produced by changes in the pleura, or in the lungs; it is now considered by most observers as settled, that they are due to changes in the pleura, not in the lungs. The late Prof. Austin Flint strongly upheld the view, that most of these sounds were produced in the lungs; but, since his decease, popular opinion has gradually drifted to the pleural view. Autopsies have confirmed this, and many good diagnosticians affirm that they have yet to hear the crepitant râle which used to be considered pathognomonic of the first stage of pneumonia; they regard it as a pleuritic friction-sound, and this view is borne out by cases of central pneumonia, in which the crepitant râle is absent.

MICROSCOPICAL DIAGNOSIS.

The recent improvements in the methods of staining the tubercle bacillus have at length enabled the microscope to occupy an important clinical position in the diagnosis of phthisis. The new rapid staining method essentially consists in having the staining fluids arranged in two solutions, the first of which stains the bacilli, and the second bleaches everything else except the bacilli, so that they stand out in strong relief and can readily be seen. The whole process is so simple that it can be performed by any practitioner in three minutes, much less time than it takes to make a thorough physical examination. If the bacilli are found, it is regarded as positive evidence of phthisis, even should the physical signs be absent, and they can often be observed before the physical signs give positive evidence of the disease.

A rather remarkable observation has lately been brought out by Prof. Reinzi, of Naples, who conducts one of the most careful cliniques in Europe. He states that the blood of all advanced phthisical patients is distinctly acid, and, according to the degree of acidity, the progress of the disease can be estimated. This fact can be readily observed by taking a very thin plaster paris disc, drawing a few drops of blood from the patient's finger and allowing it to filter through the disc on to some delicate test paper beneath. Nothing but serum percolates through, and the acid reaction can be distinctly appreciated. From this he concludes that, by keeping the blood alkaline by the administration of alkalies, the progress of the disease can be checked, not stopped. Observations are being made to test the value of this theory, but as yet it is too early to state the results.

TREATMENT.

No specific has yet been discovered, and the treatment is still symptomatic. If the patient is in good pecuniary circumstances, he is sent to some high and dry climate like Colorado or New Mexico. Many writers in the medical journals have published, during the last year, accounts of reported cures by the inhalation of hydrofluoric

acid gas; this method consists in placing the patient, for an hour each day, in an air-tight room, the atmosphere of which is impregnated with hydrofluoric acid gas. Garcin, of Paris, reports 100 cases, out of which 35 were cured, 41 improved, 14 remained in same condition, and 10 died. As a matter of fact, this method was carefully tried in Bellevue Hospital last summer, on six patients, and the treatment continued steadily for two months, with the result that all six are now in their graves. Bergeon's method, by rectal injections of hydrogen-sulphide and the pneumatic cabinet, have been abandoned. Prof. Flint advocates inhalation of creasote, but his observations have not been confirmed by others.

Selected Articles.

DISINFECTION AND DISINFECTANTS.

(Concluded.)

FURNITURE AND ARTICLES OF WOOD, LEATHER, AND PORCELAIN.

Washing, several times repeated, with:
1. Solution of carbolic acid, 2 per cent.

FOR THE PERSON.

The hands and general surface of the body of attendants of the sick, and of convalescents, should be washed with:
1. Solution of chlorinated soda diluted with nine parts of water, 1 : 10.
2. Carbolic acid, 2 per cent. solution.
3. Mercuric chloride, 1 : 1,000.

FOR THE DEAD.

Envelop the body in a sheet thoroughly saturated with:
1. Chloride of lime in solution, 4 per cent.
2. Mercuric chloride in solution, 1 : 500.
3. Carbolic acid in solution, 5 per cent.

FOR THE SICK-ROOM AND HOSPITAL WARDS.

(*a*) While occupied, wash all surfaces with:
1. Mercuric chloride in solution, 1 : 1,000.
2. Carbolic acid in solution, 2 per cent.

(*b*) When vacated, fumigate with sulphur dioxide for twelve hours, burning at least three pounds of sulphur for every 1,000 cubic feet of air-space in the room; then wash all surfaces with one of the above-mentioned disinfecting solutions, and afterward with soap and hot water; finally throw open doors and windows, and ventilate freely.

FOR MERCHANDISE AND THE MAILS.

The disinfection of merchandise and the mails will only be required under exceptional circumstances; free aeration will usually be sufficient. If disinfection seems necessary, fumigation with sulphur dioxide will be the only practicable method of accomplishing it without injury.

RAGS.

(*a*) Rags which have been used for wiping away infectious discharges should at once be burned:

(*b*) Rags collected for the paper-makers during the prevalence of an epidemic should be disinfected before they are compressed in bales, by:
1. Exposure to super-heated steam of 105° C. (221° Fahr.) for ten minutes.
2. Immersion in boiling water for half an hour.

SHIPS.

(*a*) Infected ships at sea shonld be washed in every accessible place, and especially in the localities occupied by the sick, with:
1. Solution of mercuric chloride, 1 : 1,000.
2. Solution of carbolic acid, 2 per cent.

The bilge should be disinfected by the liberal use of a strong solution of mercuric chloride.

(*b*) Upon arrival at a quarantine station, an infected ship should at once be fumigated with sulphurous acid gas, using three pounds of sulphur for every 1,000 cubic feet of air-space; the cargo should then be discharged on lighters; a liberal supply of the concentrated solution of mercuric chloride (4 oz. to the gallon) should be thrown into the bilge, and at the end of twenty-four hours the bilge-water should be pumped out and replaced with pure sea-water: this should be repeated. A second fumigation, after the removal of the cargo, is recommended; all accessible surfaces should be washed with one of the disinfecting solutions heretofore recommended, and subsequently with soap and hot water.

FOR RAILWAY CARS.

The directions given for the disinfection of dwellings, hospital wards, and ships, apply as well to infected railway cars. The treatment of excreta with a disinfectant, before they are scattered along the tracks, seems desirable at all times, in view of the fact that they may contain infectious germs. During the prevalence of an epidemic of cholera this is imperative. For this purpose the standard solution of chloride of lime is recommended.

At the annual meeting of the Sanitary Council of the Mississippi Valley, held in New Orleans, La., March 10, 11, 1885, the following resolution was adopted:

Resolved—That the Secretary request from the chairman of the Committee on Disinfectants, appointed at the

last meeting of the American Public Health Association, a plain, practical paper on "Disinfection and Disinfectants," for popular use and distribution, to be furnished to the chairman or the special committee of this council on General Sanitation.

In compliance with this request a Preliminary Report was prepared, which has been quite widely circulated. This report having been made before the experimental researches of the committee were completed, and being a "Preliminary Report," was only intended to serve a temporary purpose; but it has been thought best to revise it, and to introduce it into this our final report, so that it may be available for distribution in a separate form, if sanitary officials find it suitable for popular use.

DISINFECTION AND DISINFECTANTS.

The object of disinfection is to prevent the extension of infectious diseases by destroying the specific infectious material which gives rise to them. This is accomplished by the use of disinfectants.

There can be no partial disinfection of such material: either its infecting power is destroyed, or it is not. In the latter case there is a failure to disinfect. Nor can there be any disinfection in the absence of infectious material. It has been proved for several kinds of infectious materials, that its specific infecting power is due to the presence of living microörganisms, known in a general way as "disease germs"; and practical sanitation is now based upon the belief that the infecting agents in all kinds of infectious material are of this nature. Disinfection, therefore, consists essentially in the destruction of disease germs.

Popularly, the term disinfection is used in a much broader sense. Any chemical agent which destroys or masks bad odors, or which arrests putrefactive decomposition, is spoken of as a disinfectant. And in the absence of any infectious disease it is common to speak of disinfecting a foul cesspool, or bad smelling stable, or privy vault. This popular use of the term has led to much misapprehension, and the agents which have been found to destroy bad odors—deodorizers—or to arrest putrefactive decomposition—antiseptics—have been confidently recommended and extensively used for the destruction of disease germs in the excreta of patients with cholera, typhoid fever, etc.

The injurious consequences which are likely to result from such misapprehension and misuse of the word disinfectant, will be appreciated when it is known that recent researches have demonstrated that many of the agents which have been found useful as deodorizers, or as antiseptics, are entirely without value, for the destruction of disease germs. This is true, for example, as regards the sulphate of iron or copperas, a salt which has been extensively used with the idea that it is a valuable disinfectant. As a matter of fact, sulphate of iron in saturated solution does not destroy the vitality of disease germs, or the infecting power of material containing them. This salt is, nevertheless, a very valuable antiseptic, and its low price makes it one of the most valuable agents for the arrest of putrefactive decomposition.

Antiseptic agents, however, exercise a restraining influence upon the development of disease germs, and their use during epidemics is to be recommended when masses of organic material in the vicinity of human habitations cannot be completely destroyed, or removed, or disinfected.

While an antiseptic agent is not necessarily a disinfectant, all disinfectants are antiseptics; for putrefactive decomposition is due to the development of "germs" of the same class as that to which disease germs belong, and the agents which destroy the latter also destroy the bacteria of putrefaction when brought in contact with them in sufficient quantity, or restrain their development when presented in smaller amounts. A large number of the proprietary "disinfectants," so-called, which are in the market, are simply deodorizers or antiseptics, of greater or less value, and are entirely untrustworthy for disinfecting purposes.

Antiseptics are to be used at all times when it is impracticable to remove filth from the vicinity of human habitations, but they are a poor substitute for cleanliness. During the prevalence of epidemic diseases, such as yellow fever, typhoid fever, and cholera, it is better to use in privy-vaults, cess-pools, etc., those antiseptics which are also disinfectants, *i.e.*, germicides; and when the contents of such receptacles are known to be infected, this becomes imperative.

Still more important is the destruction at our seaport quarantine stations of infectious material which has its origin outside of the boundaries of the United States, and the destruction within our boundaries, of infectious material given off from the persons of those attacked with any infectious disease, whether imported or of indigenous origin.

In the sick-room we have disease germs at an advantage, for we know where to find them as well as how to kill them. Having this knowledge, not to apply it would be criminal negligence, for our efforts to restrict the extension of infectious diseases must depend largely upon the proper use of disinfectants in the sick-room.

GENERAL DIRECTIONS.

Disinfection of Excreta, etc. The infectious character of the dejectious of patients suffering from cholera and from typhoid fever is well established; and this is true of mild cases and of the earliest stages of these diseases as well as of

severe and fatal cases. It is probable that epidemic dysentery, tuberculosis, and perhaps diphtheria, yellow fever, scarlet fever, and typhus fever, may also be transmitted by means of the alvine discharges of the sick. It is therefore of the first importance that these should be disinfected. In cholera, diphtheria, yellow fever, and scarlet fever, all vomited material should also be looked upon as infectious. And in tuberculosis, diphtheria, scarlet fever, and infectious pneumonia, the sputa of the sick should be disinfected or destroyed by fire. It seems advisable also to treat the urine of patients sick with an infectious disease with one of the disinfecting solutions below recommended.

Chloride of lime, or bleaching powder, is perhaps entitled to the first place for disinfecting excreta on account of the rapidity of its action. The following standard solution is recommended:

Dissolve chloride of lime of the best quality in pure water, in the proportion of six ounces to the gallon.

Use one quart of this solution for the disinfection of each discharge in cholera, typhoid fever, etc. Mix well, and leave in the vessel for at least one hour before throwing into privy-vault or water-closet. The same directions apply for the disenfection of vomited matters. Infected sputum should be discharged directly into a cup half-full of the solution. A 5 per cent. solution of carbolic acid may be used instead of the chloride of lime solution, the time of exposure to the action of the disinfectant being four hours.

Disinfection of the person. The surface of the body of a sick person, or of his attendants, when soiled with infectious discharges, should be at once cleansed with a suitable disinfecting agent. For this purpose solution of chlorinated soda (liquor sodæ chlorinatæ) diluted with nine parts of water, or the standard solution of chloride of lime diluted with three parts of water, may be used. A 2 per cent. solution of carbolic acid is also suitable for this purpose, and under proper medical supervision the use of a solution of corrosive sublimate—1:1,000—is to be recommended.

In diseases like small-pox and scarlet fever, in which the infectious agent is given off from the entire surface of the body, occasional ablutions with the above mentioned solution of chlorinated soda are recommended.

In all infectious diseases the body of the dead should be enveloped in a sheet saturated with the standard solution of chloride of lime, or with a 5 per cent. solution of carbolic acid, or a 1:500 solution of corrosive sublimate.

Disinfection of clothing. Boiling for half an hour will destroy the vitality of all known disease germs, and there is no better way of disinfecting clothing or bedding which can be washed than to put it through the ordinary operations of the laundry. No delay should occur, however, between the time of removing soiled clothing from the person or the bed of the sick and its immersion in boiling water, or in one of the following solutions until this can be done:

Corrosive sublimate one drachm to the gallon of water (about 1:1,000), or,

Carbolic acid, pure, one ounce to the gallon of water (1:128).

The article to be disinfected must be thoroughly soaked with the disinfecting solution and left in it for at least two hours, after which they may be wrung out and sent to the wash.

N. B. Solutions of corrosive sublimate should not be placed in metal receptacles, for the salt is decomposed and the mercury precipitated by contact with copper, lead, or tin. A wooden tub or earthen crock is a suitable receptacle for such solutions.

Clothing or bedding which cannot be washed should be disinfected by steam in a properly constructed disinfection chamber. In the absence of a suitable steam disinfecting apparatus, infected clothing and bedding should be burned.

Disinfection of the sick-room. In the sick-room no disinfectant can take the place of free ventilation and cleanliness. It is an axiom in sanitary science that it is impracticable to disinfect an occupied apartment, for the reason that disease germs are not destroyed by the presence in the atmosphere of any known disinfectant in respirable quantity. Bad odors may be neutralized, but this does not constitute disinfection in the sense in which the term is here used. These bad odors are, for the most part, an indication of want of cleanliness, or of proper ventilation; and it is better to turn contaminated air out of the window or up the chimney than to attempt to purify it by the use of volatile chemical agents, such as carbolic acid, chlorine, etc., which are all more or less offensive to the sick, and are useless so far as disinfection—properly so called—is concerned.

When an apartment which has been occupied by a sick person with an infectious disease has been vacated, it should be disinfected. The object of disinfection in the sick-room is mainly the destruction of infectious material attached to surfaces, or deposited as dust upon window ledges, in crevices, etc. If the room has been properly cleansed and ventilated while still occupied by the sick person, and especially if it was stripped of carpets and unnecessary furniture at the outset of his attack, the difficulties of disinfection will be greatly reduced.

All surfaces should be thoroughly washed with the standard solution of chloride of lime diluted with three parts of water, or with 1:1,000 solution of corrosive sublimate. The walls and ceiling, if plastered, should be subsequently treated with a lime-wash. Especial care must be taken to wash

away all dust, from window ledges and other places where it may have settled, and thoroughly to cleanse crevices and out-of-the-way places. After this application of the disinfecting solution, and an interval of twenty-four hours or longer for free ventilation, the floors and wood-work should be well scrubbed with soap and hot water, and this should be followed by a second, more prolonged exposure of fresh air, admitted through open doors and windows.

As an additional precaution, fumigation with sulphurous acid gas is to be recommended, especially for rooms which have been occupied by patients with small-pox, scarlet fever, diphtheria, typhus fever and yellow fever. But fumigation with sulphurous acid gas alone, as commonly practised, cannot be relied upon for disinfection of the sick-room and its contents, including bedding, furniture, infected clothing, etc., as is popularly believed.

When fumigation is practised, it should precede the general washing with a disinfecting solution heretofore recommended. To ensure any results of value, it will be necessary to close the apartment to be disinfected as completely as possible by stopping all apertures through which the gas might escape, and to burn not less that three pounds of sulphur for each thousand cubic feet of air space in the room. To secure complete combustion of the sulphur, it should be placed in powder or in small fragments, in a shallow iron pan, which should be set on a couple of bricks in a tub partly filled with water, to guard against fire. The sulphur should be thoroughly moistened with alcohol before igniting it.

Disinfection of privy vaults, cesspools, etc. When the excreta (not previously disinfected) of patients with cholera or typhoid fever have been thrown into a privy vault, this is infected, and disinfection should be resorted to as soon as the fact is discovered, or whenever there is reasonable suspicion that such is the case. It will be advisable to take the same precautions with reference to privy vaults into which the excreta of yellow fever patients have been thrown, although we do not definitely know that this is infectious material.

For this purpose the standard solution of chloride of lime may be used in quantities proportioned to the amount of material to be disinfected, but where this is considerable it will scarcely be practicable to sterilize the whole mass. The liberal and repeated use of this solution, or of a 5 per cent. solution of carbolic acid will, however, disinfect the surface of the mass, and is especially to be recommended during the epidemic prevalence of typhoid fever or of cholera.

All exposed portions of the vault, and the wood-work above it, should be thoroughly washed down with the disinfecting solution. Instead of the disinfecting solutions recommended, chloride of lime in powder may be daily scattered over the contents of the privy vault.

Disinfection of ingesta. It is well established that cholera and typhoid fever are very frequently, and perhaps usually, transmitted through the medium of infected water or articles of food, and especially milk. Fortunately we have a simple means at hand for disinfecting such infected fluids. This consists in the application of heat. The boiling temperature maintained for half an hour kills all known disease germs. So far as the germs of cholera, yellow fever, and diphtheria are concerned, there is good reason to believe that a temperature considerably below the boiling point of water will destroy them. But in order to keep on the safe side, it is best not to trust anything short of the boiling point (212° F.) when the object is to disinfect food or drink which is open to the suspicion of containing the germs of any infectious disease.

During the prevalence of an epidemic of cholera it is well to boil all the water for drinking purposes. After boiling, the water may be filtered, if necessary to remove sediment, and then cooled with *pure* ice if desired.—*Jour. Am. Med. Assoc.*

DISEASES WITH PERSONAL NAMES.

The *Union Médicale du Nord-Est* publishes in its last issue a very interesting article from the *Gazette Médicale, de Strasborg*, in which the writer points out the inconveniences resulting from the use of personal names in the designation of diseases. He terminates his article with a list of these names, which we place before our readers :

Addison's disease. Suprarenal cachexia; bronzed skin disease.

Addison's keloid (or cheloid). Cancroid, or Morphew.

Alibert's disease. Fungoid mycosis.

Aran-Duchenne's disease. Progressive muscular atrophy.

Astley Cooper's hernia. Crural hernia involving the superficial fascia.

Argyll-Robertson's sign. Absence of pupilar reflex.

Basedow's disease. Exophthalmic goitre.

Bazin's disease. Buccal psoriasis.

Béclard's hernia. Hernia across the saphena.

Bell's paralysis. Paralysis of seventh pair.

Bergeron's disease. Localized rhythmic chorea.

Boudin's law. Antagonism of impaludism and tuberculosis.

Boyer's cyst. Sub-hyoiden cyst.

Bright's disease. Nephritis (albuminous).

Brown-Sequard's syndrome. Hemiparaplegia with hemianesthesia of the opposite side.

Cazenave's lupus. Erythematous lupus.

Charcot's disease. Ataxic arthropathy.

Cheyne-Stokes' respiration. Uræmic resp.

Cloquet's hernia. Perineal hernia.

Colles' law. Non-infection of the mother by her syphilitic child.

Corrigan's disease. Aortic insufficiency.

Corvisart's facies. Asysystolic facies.

Cruveilhier's disease. Simple ulcer of the stomach.

Donder's glaucoma. Simple atrophic glaucoma.

Dressler's disease. Paroxysmal hemoglobinuria.

Dubini's disease. Electric chorea.

Duchenne's disease. Locomotor ataxia.

Duchenne's paralysis. Pseudo-hypertrophic paralysis.

Duhring's disease. Herpetiform dermatitis.

Dupuytren's disease. Retraction of the palmar aponeurosis.

Dupuytren's hydrocele. Hydrocele interna.

Eichstedt's disease. Pityriasis versicolor.

Erasmus Wilson's disease. Generalized exfoliating dermatitis.

Erb's paralysis. Radicular paralysis of the brachial plexus.

Erb-Charcot's disease. Spasmodic dorsal tabes.

Fouchard's disease. Alveo-dental periostitis.

Friederich's disease. Hereditary locomotor ataxia.

Gerlier's disease. Paralytic vertigo.

Gilbert's pityriasis. Pityriasis rubra.

Gibbon's hydrocele. Hydrocele with hernia.

Gilles de la Tourette's disease. Motor incöordination with acholia and coprostasis.

Goyrand's hernia. Interstitial inguinal hernia.

Grave's disease. Exophthalmic goitre.

Graefe's (von) sign. Dissociation of movement between the globe of the eye and the upper eyelid.

Guyon's sign. Fluctuation on renal succussion.

Harley's disease. Paroxysmal hemoglobinuria.

Heberden's rheumatism. Rheumatism of the small joints, with nodes.

Hebra's disease. Polymorphous erythema.

Hebra's pityriasis. Chronic pityriasis rubra.

Hebra's prurigo. True idiopathic prurigo.

Henoch's purpura. Purpura with intestinal symptoms.

Heselbach's hernia. Crural hernia; multilocular sac.

Hippocratic face. Facies cadaverica.

Hodgkin's disease. Adenia; lymphadenoma.

Hodgson's disease. Atheroma of the aorta.

Huguier's disease. Uterine fibro-myoma.

Hutchinson's tooth. Syphilitic tooth (semilunar and notched on the free border).

Hutchinson's triad. The notched tooth; interstitial keratitis and hereditary syphilitic otitis.

Jacob's ulcer. Cancroidal ulcer.

Jacksonian epilepsy. Partial epilepsy.

Kopp's asthma. Thymic asthma; spasm of the glottis.

Kaposi's disease. Xeroderma pigmentosum.

Kronlein's hernia. Inguinal properitoneal hernia.

Laennec's cirrhosis. Atrophic cirrhosis.

Landry's disease. Acute ascending paralysis.

Laugier's hernia. Hernia across Gimbernat's ligament.

Leber's disease. Hereditary optic atrophy.

Levret's law. Marginal insertion of the cord in placenta prævia.

Littre's hernia. Diverticular hernia.

Ludwig's angina. Infectious sub-hyoiden phlegmon.

Mallassez's disease. Cystic disease of the testicle.

Menière's disease. Labyrinthine vertigo.

Millar's asthma. Stridulous laryngitis.

Morand's foot. Foot with eight toes.

Morvan's disease. Analgesic paresis of the extremities.

Paget's disease. Pre-cancerous eczema of the nipple.

Paget's disease. Hypertrophic osteitis deformans.

Parrot's disease. Syphilitic pseudo-paralysis.

Parrot's sign. Dilatation of the pupil by pinching the skin (meningitis.)

Parkinson's disease. Paralysis agitans.

Parry's disease. Exophthalmic goitre.

Pavy's disease. Intermittent albuminuria.

Petit's hernia. Lumbar hernia.

Pott's aneurism. Aneurism by anastomosis.

Pott's fracture. Fracture of the fibula by divulsion.

Pott's disease. Vertebral osteitis.

Raynaud's disease. Symmetrical strangulation of the extremities.

Reclus' disease. Cystic disease of the mamma.

Richter's hernia. Parietal enterocele.

Rivolta's disease. Actinomycosis.

Romberg's sign. Vacillation of ataxic patients in the dark.

Rosenbach's sign. Abolition of the abdominal reflex.

Sœmisch's ulcer. Infectious ulcer of the cornea

Stork's blenorrhœa. Blenorrhœa of the superior respiratory passages.

Stokes' law. Paralysis of the muscles subjacent to the inflamed serous and mucous membranes.

Sydenham's chorea. Common chorea.

Thomsen's disease. Muscular spasm at the commencement of voluntary movements.

Thornwald's disease. Inflammation of the pharyngeal gland of Luschka.

Velpeau's hernia. Crural hernia in front of the vessels.

Volkmann's deformity. Congenital tibiotarsian luxation.

Wardrop's malady. Malign onyxis.

Weil's disease. Abortive typhus with icterus.

Wells' facies. Ovarian facies.

Werlhoff's disease. Purpura hemorrhagica.

Westphall's sign. Abolition of the rotulian reflex.

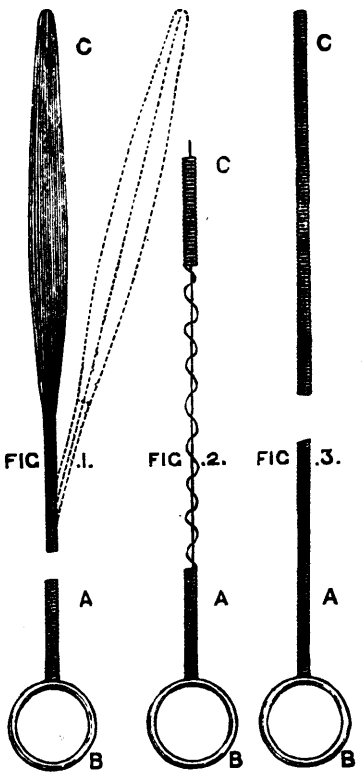
Willan's lupus. A tuberculous form of lupus.

Winckel's disease. Pernicious cyanosis of the new-born infant.—*Le Prog. Méd. N. Y. Med. Abstr.*

A NEW METHOD OF TREATMENT FOR ENDOMETRITIS AND ENDO-CERVICITIS BY MEANS OF MEDICATED BOUGIES.

Whilst the several forms of chronic inflammation included under the above heading are amongst the commonest kinds of uterine disease which come under general hospital treatment, they are also amongst those in which the result of that treatment is the least satisfactory. Nor do they fare any better in private practice, when perhaps greater attention can be paid to individual cases than is possible in the out-patient room of a hospital, so that they often come, and not altogether unjustly, to be classed amongst the often-spoken-of *opprobia medicinæ*. Various reasons may be given for this. First, there is sometimes a certain sense of inaccessibility surrounding the uterus when the question of local treatment of its interior comes under consideration. Then, again, it is to be feared that there are still a few who regard disease of the female pelvic organs as a something almost apart from general surgery as dominated by the ordinary laws of physiology and pathology, who cannot bring themselves to look upon an inflammation of the lining membrane of the uterus by the same light as that with which they would view, say, an inflammation of the urethra in the male. Above and beyond all this, there is the difficulty, even the impossibility, of obtaining for the organ in question any near approach to that first and most important element in the treatment of inflammation, upon which Hunter insisted and Hilton discoursed so eloquently—physiological rest. In the case of the uterus, the ever-recurring phenomena attendant upon ovulation, the congestion of the pelvic organs accompanying sexual intercourse, and probably, though to a lesser extent, sexual emotion, will render the attainment of even comparative rest a matter of the greatest difficulty. Not, indeed, that the uterus is singular amongst the viscera in this respect, but with it the difficulty is perhaps better exemplified than with any other.

These things being so, any attempt to simplify and render more effectual the treatment of such cases would seem to be justifiable, and, with that end in view, I wish to call attention to a method of applying local remedies to the mucous membrane of the uterus by means of bougies, which I have been using for some little time past in my out-patient room. The accompanying sketches of the bougies will need but few words of explanation.* (Figs. 1, 2, 3.) The instrument is made of a single piece of fine spiral wire similar to that used for urethral "antrophores." The stem, five inches and a half in length, is stiffened so that it can be bent to any angle required, and so that by it the medicated portion may be guided into the uterus. The medicated portion, an inch and a half in length, contains stiffening only in its first half-inch, and may be coated with any drug that the fancy of the practitioner, or the needs of the case may indicate. The ones which I have myself used have been coated with one of the following: iodo-



form, 20 per cent.; argentic nitrate, 2 per cent.; thallin sulphate, 5 per cent. I am also hoping to get a satisfactory bougie prepared containing pure iodine. Other drugs that will at once suggest themselves as appropriate to the purpose are zinc and cupric sulphates, alum, tannin, and plumbic subacetate. The medicated spiral wire portion possesses the qualities of pliancy and softness, combining with them, however, sufficient stiffness to render its guidance into the body of the uterus a matter of ease in most cases. The bougie is passed up the os through a Fergusson's or bivalve specu-

* For the ordinary run of cases a bougie of somewhat smaller size than that depicted will be found convenient.

lum, the stem being first bent just below its upper termination so as to adapt the instrument, more or less, to the utero-vaginal curve. Before being used, the medicated portion is dipped into cold water in order to remove the powdered talc with which it is coated externally; its action will also be rendered more efficient if the cervical canal is well cleaned out as a preparatory step. The instrument is left in position for from fifteen to twenty minutes, by the end of which time the medicated coating will have dissolved. It is then withdrawn, by the patient herself if necessary, and the recumbent position is to be continued as long as may be convenient, an hour or more if possible, so that the application may remain in contact with the uterine mucous membrane sufficiently long to be productive of benefit.

The frequency with which these bougies are to be used will vary with individual cases, and according to the nature of the coating of the bougie. When iodoform is used, one bougie a day may be passed in most cases; with nitrate of silver, especially if a stronger percentage than that mentioned above be used—as it often might be with advantage—every second or third day will be sufficient. In connection with the bougies, other curative measures may of course be adopted: local depletion by puncture about the os, or by means of vaginal glycerine pledgets of cotton wool; painting of epithelial erosions of the vaginal portion of the cervix, when present, with tincture of iodine or nitric-acid. With respect to the passage of the bougies, however, in some cases a difficulty will arise from smallness of the os and narrowness of the cervical canal. The commonest cases, in my practice at any rate, are those dating from childbirth, either endo-metritis and endo-cervicitis combined, or the latter alone. In such cases the canal is of fair size, and the os usually patulous, and so, as noted before, the bougie can be passed with ease. But in another important clinical group of cases—viz., those occurring chiefly amongst nulliparous married women and reputed virgins, in whom, nevertheless, I believe that the metritis is most frequently but the upward march of gonorrhœal vaginitis—a different condition of things prevails. Here the fundal inflammation is more marked than the cervical; the vaginal portion of the cervix will be seen to be swollen and congested, the os itself small. The discharge, flowing freely from the os as the Fergusson's speculum is pushed home, instead of presenting the viscid opaque characteristics of abnormal cervical secretion, will be comparatively thin and of greenish color, resembling, in fact, the "laudable pus" of the older surgeons, and so indicating the fundus of the uterus as being its principal source. In these cases, then, the smallness of the os will present some difficulty, but in them I have nearly always succeeded in introducing an instrument, after rapid dilatation with a three-bladed dilator if necessary. This preliminary dilatation of an inflamed os is, I believe, in itself more or less of an evil. But what alternative is there? From no drug whatever, administered internally, can we hope to get the slightest relief. The patient's general condition may, it is true, be improved by iron or other tonics, but the disease itself will remain. The inflammation is a local disease, and amenable only to local treatment. If, on the other hand, it be neglected, it too often (though insignificant as far as life itself is concerned) entails an immense amount both of mental and bodily suffering, reducing the patient ultimately to a miserable state of hypochondriasis.

In connection with the foregoing remarks, I wish it to be understood that I do not place any great importance on an exact differential diagnosis between endo-metritis and endo-cervicitis, so far at least as regards treatment. In many cases we can safely infer that the cervical canal is alone affected; but in at least an equal number it is almost impossible to say for certain that the disease is limited to above or to below the os internum; quite impossible to localize a particular spot in the area of the fundus as being alone the seat of inflammation. Examination of the cavity by endoscopy might perhaps give us more precise information on this and other points. This much, however, I think can be said: that after a general inflammation—following gonorrhœal infection, for instance—of the uterine mucous membrane has all but subsided, there is a tendency for the disease to perpetuate itself as chronic cervical catarrh, in the same way that, after acute urethritis, the bulbo-membranous portion of the urethra so often becomes the seat of a chronic indolent ulceration. This tendency of the inflammation to linger in a chronic form about the cervix after it has subsided in the fundus, may perhaps be explained by the normally rugose condition of the lining membrane of the former, and by the abundance of glands and mucous follicles opening on its surface, conditions which together would greatly favor this result.

In conclusion, I would claim for the bougies that they possess certain advantages over most of the methods in general use for applying drugs to the interior of the uterus, whether by syringes, insufflators, or ointment repositors. They are easy of introduction, could scarcely be made to inflict mechanical injury on the uterus, and the application used is distributed thoroughly and uniformly throughout its cavity. An additional point in their favor is that they contain the drug required in a very portable and cleanly form, and are always ready for immediate use. When, however, liquid caustics, as nitric or carbolic acid, are required, the bougies are necessarily out of the question. It is also suggested that in midwifery practice the daily passage of an iodoform bougie after parturition would be an efficient means of keeping aseptic the

cavity of the uterus in cases where there are retained shreds of placenta or blood clot, or in other circumstances which might seem to demand unusual precautions. My thanks are due to Messrs. Christy & Co., the makers of the bougies, for the great trouble they have taken to produce an instrument which would fulfil my requirements, and for their liberality in placing a considerable quantity of them at my disposal for use in the hospital.—A. G. R. Foulerton, L.R.C.P., etc., in *Lancet*.

AN IMPROVED METHOD OF MANAGING THE THIRD STAGE OF LABOR, WITH A CRITICISM OF THE THEORY THAT THE PLACENTA IS THEN SEPARATED BY THE UTERINE PAINS.

1. At the beginning of labor the placenta and uterus are together to be considered as made up of the following parts, so far as the question of separation is concerned :

(*a*) *The part to be separated*, comprising amnion, chorion, chorionic villi, intervillous spaces, large-celled layer of serotina.

(*b*) *The line of separation*, lying between the large-celled and small-celled layers of the placenta, and termed the trabecular layer. It is formed chiefly by the persistent fundi of the uterine glands.

(*c*) *The part left behind* after the placenta is separated, and consisting of the small-celled layer with remains of uterine glands, smaller in lumen, set on the uterine muscle.

2. The chorionic villi get their blood-supply from the umbilical arteries of the fœtus. The intervillous spaces have blood poured into them from the maternal circulation, the blood passing by the curling arteries into the spaces, and from these into the uterine sinuses by the slanting veins. The venous supply of the uterus is much more abundant than the arterial.

3. At the trabecular layer we may regard the placental area (that is, uterine surface of separated placenta) and placental site as coinciding during pregnancy, with trabecular layer joining them.

4. Separation of the placenta can only take place when there is disproportion between placental area and placental site.

5. The placenta does not separate during the first and second stages of labor, because all changes in the placental site (diminution during pains and expansion when pain dies off) are accurately responded to by the placenta, owing to the activity of the fœtal and maternal blood-supplies.

6. During the third stage of labor the fœtal circulation is cut off and the villi are closely pressed together, showing obliteration of intervillous spaces. The increase in placental site following a third-stage pain is not followed up by the placental area, as the placenta is now practically a bloodless structure.

7. The placenta does not separate on diminution of placental site to 4″ x 4″.

8. Any diminution of site below this introduces no relative change at plane of separation. The area of the placental site and the placenta still correspond.

9. A disproportion in area between the placental site and placenta brings about tension on the trabeculæ of the trabecular layer, that is, tears them.

10. This disproportion happens during the third stage in the relaxation following a pain, and therefore separation occurs after the pain. During the relaxation the placental site increases slightly, but the placenta, now bloodless, or nearly so, does not respond ; hence disproportion of area.

11. The placenta, when separated, is expelled by the pains either as Duncan or Schultze has figured.

12. All separation of placenta or membranes follow one mechanism—"*Placenta and membranes separate when there is a disproportion at the plane of separation between their area and their site of attachment. This disproportion is only slight, as the trabeculæ are microscopic.*"

The gist of the view advocated is that the placenta separates in third stage after the pains, and is expelled when separated by the pains. The important practical point is that manipulation can not separate the placenta, but can only aid expulsion.

From the above demonstration, Hart has formulated the following rules for the management of the third stage of labor.

1. When the child is born, note that the fundus uteri stands at or below the level of the umbilicus, and that the uterus does not contain a second child. Give an ergotine injection in a multipara at any rate, if labor has been slow.

2. Do not tie the cord until the child has cried freely, and then tie only one ligature.

3. Cut the cord on the placental side of the ligature, and let the placental part of the cord drain thoroughly into any small dish ; then tie it, to prevent any staining of the bed linen. Tie a second ligature at once, however, if a second child be present.

4. Before applying the first ligature, it should be thoroughly ascertained by abdominal palpation that the uterus is not so relaxed as to bleed.

5. Continue with the hand on the uterus ; do nothing when a good contraction comes on, and allow the uterus its normal relaxation after the pain is over.

6. Should bleeding from the uterus come on, or

should the pains be feeble, than grasp the uterus so as to bring on a contraction to arrest hæmmorrhage.

7. Do nothing further in a normal case until the lessening of the bulk of the uterus shows that the placenta is separated and being expelled; the expulsion may then be aided by "expression."

8. One can tell when the placenta is separated and not driven down by noting that gentle expression drives it down.

The reasons for the above treatment are as follows: Ergotine and manipulation are used to insure good marked retraction and to empty the intervillous spaces well. The fœtal circulation is aspirated thoroughly by allowing the child to cry well, and by draining the cord. These two measures give the necessary disproportion sooner, as the placenta can not now follow up the increase in placental area during relaxation, is made as small in area as possible, and relaxation thus sooner tears the trabeculæ.

Since practising this procedure, Hart has had no difficulty in the normal third stage of labor. Interference is reduced to a minimum, and the membranes expelled intact.—D. Berry Hart in *Ed. Med. Jour.*

MEDICAL NOTES.

A good application for *burns* is the following:

℞.—Salol, ... p. j.
Ol. olivæ, ... p. vj.
Aquæ calcis, ... p. vj. M.

A solution of chromic acid is perhaps the best application to *mucous patches* (*Cinn. Lancet-Clinic*, July 28), especially to those in the mouth and the pharynx. Use from two to five grains to the ounce.

When *constipation exists in women* who menstruate profusely, as in rheumatic subjects, the *Med. Press* says: Equal parts of flowers of sulphur and calcined magnesia, mixed with an equal bulk of cream of tartar, will be found an excellent laxative.

A useful liniment in *neuralgia* is the following:

℞.—Spirit. camphor., . . . p. 90
Æther., ... p. 30
Tinct. opii, ... p. 6
Chloroform., ... p. 20. M.

Apply with a flannel.

A palatable cod-liver oil for children may be prepared as follows (*Am. Pract.*):—

Florida orange wine, . . . ℥ vj.
Cod-liver oil, ... ℥ ij.
Extract of pancreatin . . gr. xx.

Shake thoroughly.

Dr. E. B. Stevens states, in *Obstet. Gazette*, Aug., 1888, that, uniformly, women who have been for some time—say one to two or three years—in the morphine habit, have an entire *arrest of menstruation*, which function is re-established under treatment for the habit.

Another external application for *neuralgia* is the following (*Med Rec.*):—Eau de Cologne, ether and chloroform, f ʒ iij of each, poured on a handkerchief previously wetted with cold water, and placed on the seat of pain, is said to give instantaneous relief. In *nervous headache* it is also efficacious.

Professor Jacqoud (*Brit. Med. Journal*) recommends a copious diluent draught and an exclusive milk diet in the treatment of *gout*: in cases in which there is considerable fever he gives a small quantity of hydrate of bromal. Preparations of colchicine and of salicylate of soda, though excellent as anæsthetics, are to be avoided. In patients affected with insterstitial nephritis these substances produce most serious toxic symptoms.

The oil of turpentine is recommended as an application to all cases involving a *solution of surface continuity from injury* (*Med. Press.*) In severe wounds of the hand or other parts, involving extensive laceration, the oil is said to prevent suppuration and sepsis, and so conduce to rapid recovery. In such cases the parts are well cleansed with hot water, and pledgets of lint steeped in the oil are applied. The dressing is kept saturated with a mixture of two parts of the oil of turpentine and one of linseed oil.—*Col. and Clin. Rec.*

PULMONARY GANGRENE TREATED BY INCISION AND DRAINAGE.

At the meeting of the Clinical Society of London, held October 12, 1888, Dr. Pasteur read a case of "Pulmonary Gangrene treated by Incision and Drainage" (*Lancet*, October 20, 1888). The patient was a delicate-looking boy, aged 7. His illness was insidious in the onset, but had developed rapidly. On the morning before admission to the North-Eastern Hospital for Children he coughed up a quantity of bright blood, and his mother noticed that his breath had become very offensive. On admission ten days after the onset, he was febrile, with thickly-coated tongue, quickened breathing, and gangrenous fetor of breath. Over the right upper lobe were impaired resonance, weak tubular breath sounds, and diminished voice conduction. During the next three weeks cavity signs developed at the right apex, and the remainder of the right lung became pneumonic. The temperature ranged between 100° and 103.6°. He spat up daily from two to four ounces of offensive watery fluid, mostly saliva. The boy was subse-

quently operated on by Mr. Pollard. The cavity was incised at the anterior extremity of the right second space, one inch from the sternum. Large quantities of gangrenous lung and putrid fluid were expelled through the wound. The cavity reached down to the sixth rib. A counter-opening was made in the sixth space, flanged tubes inserted, and a blue wool dressing applied. Next morning the child was much relieved, nearly free from cough, expectorating small quantities of frothy sputum almost free from odor, and practically free from pain, which had hither to be enamost distressing symptom. The cavity was washed out daily once or twice as occasion required. At the end of a week the washings deposited a copious sediment of pus. The improvement, however, was not maintained. The temperature, pulse, and respirations remained high, fetor of breath re-appeared on the tenth day, and the patient sank rapidly three days later. A huge cavity occupied the anterior third of the right lung. It was lined for the most part with a thin layer of granulation-tissue. At the inner margin the necrotic process had invaded the pericardium and set up acute pericarditis. The œsophagus was firmly adherent to the right bronchus, and a narrow sinus, about three-quarters of an inch long, led from a minute valve-like opening in the œsophagus to a small ragged opening in one of the main divisions of the right bronchus. There were no signs of tubercle or of caseating or suppurating bronchial glands. The gangrene was undoubtedly due to the passage from the œsophagus into the lung of some irritative material (probably decomposing foodstuffs) along the sinus above mentioned. Whether this sinus was the remains of a glandular abscess or was caused by the passage of some pointed foreign body from the œsophagus was doubtful. The limitation of the gangrene of the anterior region of the lung, and the implication of all three lobes in a single cavity, were worthy of notice. Pericarditis appeared to be a rare complication of pulmonary gangrene. The indications for surgical interference were sufficiently clear,—viz., imperfect communication of the gangrenous area with the bronchi, failure of expectant treatment, and signs of a cavity in an accessible situation. The amount of repair which took place under unfavorable circumstances was very encouraging. An earlier operation might have saved the life of the patient.

Mr. Godlee mentioned a case of gangrenous cavity at the apex of one lung, which was opened and drained; the pleura was not adherent, necessitating the sewing of the pulmonary to the costal pleura before the abscess was opened. The child died in two days, and then it was found that another gangrenous cavity existed in the opposite lung.

Dr. Broadbent said he only saw in one case an attempt made to reach a gangrenous cavity in the base of the lung; but no relief followed.

Dr. Barlow related a case of gangrenous mediastinal abscess involving the lung by extension, and into which a sinus led from the gullet; probably the gangrene was secondary to perforation of the gullet by a foreign body. In cases of gangrene due to a discharge of a bronchial abscess into a bronchus, the œsophagus has not been in communication with the abscess cavity.—*Therap. Gaz.*

THE INFANT FOOD PROBLEM.

In the January issue is a very interesting and useful paper on this subject, taken from *The Sanitarian*. We now copy from the same source the following leading facts obtained in reply to questions on this subject, submitted to Dr. Eustace Smith, of London; Dr. J. Lewis Smith, of New York; Dr. Victor C. Vaughan, of Ann Arbor, Mich.; Dr. George H. Rohé, of Baltimore; Dr. F. Forchheimer, of Cincinnati; and others.

1. In the case of an infant, or a child under ten months of age, deprived of breast-milk, the artifical substitute provided should be made to correspond with human milk as closely as possible, both in its chemical constitution and in its physical characters.

2. Fresh, unadulterated cows' milk, when properly prepared, is an acceptable substitute for breast-milk. But since the casein of cows' milk coagulates in a heavy, dense mass, white breast-milk curd is light and flocculent, some expedient must be resorted to in order to make the former resemble the latter, so that the digestive powers of the infant shall not be unduly taxed. The casein of cows' milk, accerding to Dr. Eustace Smith, as the rule, traverses the infant's alimentary tract and may be found unchanged in the fæcal discharges. It is therefore a constant source of irritation, and often gives rise to diarrhœa and entero-colitis. One of the most decided advances in dietetics in modern times, is the preparation of cows' milk with the aid of digestive agents, as in the method recommended by Professor Frankland. In this method the casein of a portion of the milk is first peptonized by fresh calves' rennet, and to this is added a portion of fresh milk, after heat has been applied to check the process and to prevent complete predigestion; some milk-sugar is finally added, and thus a mixture is obtained which closely approximates human milk in its chemical composition. It has, however, been found to serve as an efficient substitute, where the mother's milk is of poor quality, is inadequate in quantity, or is entirely wanting. The special feature of this method is the peptonizing of only a part of the casein, with the employment of heat at a certain stage to arrest the process so that the food shall not be completely digested. The addition of the carbo-hydrate (milk-sugar in this case) is necessary,

in order that the food shall closely resemble human milk. The employment of stale, foul-smelling, partially decomposed digestive ferments, for the purpose of preparing cows' milk for infants' food is condemned. The necessary skill and intelligence required to insure uniformity of result for the extemporaneous peptonizing of milk is rarely to be found in the household, and where this process is adopted, the experiment often turns out to be unfortunate and injurious to the child.

3. As a rule, raw starch is inadmissible in the diet of young infants, because the digestive powers of the infant are rarely sufficiently active to convert crude starch into a soluble form. The plan advocated by some, of adding the starch to the milk in order to mechanically break up the curd, is unphysiological and very objectionable. The products of the complete digestion of starch are glucose and saccharose (maltose), and these, in various forms have been recommended to be used as additions to the milk, under the name of "Liebig Foods." When in excess, these substances cause diarrhœa, and when given alone do not sufficiently nourish the child. Dr. J. Lewis Smith speaks favorably of dextrine, which is a partially digested starch, as a good substitute for glucose and saccharose in such artificial foods. The fact cannot be too strongly insisted upon, which is taught both by clinical experience and by physiological investigation, that the food of either infants or adults, except in special emergencies, should never be fully predigested, for fear of permanently weakening or destroying the digestive functions of the stomach.

4. A great part of the large mortality of infants in all our cities is due to the bad quality of the milk supply, particularly that going to the poorer classes. Professor Vaughan declares that many deaths from so-called cholera-infantum are really caused by milk containing tyrotoxicon. Authorities are almost unanimous upon the point that in large cities, at least during hot weather, all milk for the nursing bottle should be boiled several times a day, in order to destroy ferment-germs. It is better, at such times, that the food should be freshly prepared for each feeding. In some cases, owing to the variability in the quality of the milk supply, it may be advisable to resort, for a short time, to condensed or evaporated milk; in either case diluting and adding cream, or an equivalent, soluble carbo-hydrate, in order to make an artificial breast-milk. Desiccated partly peptonized milk, in the form of a milk food, containing partly converted starch (soluble starch and dextrine), and a small quantity of lactose is a convenient (and when well made, a very efficient) substitute for the mother's milk.

5. Where a child is a premature birth, or is feeble from other causes, as great care should be observed in preparing its food as in prescribing its medicine. Experience has demonstrated that success in infant-feeding is dependent upon the ability to individualize the patient, and to select the proper food for each case. For very delicate infants the mother's milk is often found not only inadequate to properly nourish the child, but also positively injurious. This is generally admitted where same obvious dyscrasia exists, as the tuberculous or syphilitic. It is a fact that in such feeble infants artificial mixtures can be made which will agree with the weak digestive functions and satisfactorily nourish the child.

SOME DERMATOLOGICAL DON'TS.

Don't make your diagnosis from the history of a case, because if you do you will often be led astray. Make it from the eruption that you see, and then substantiate or destroy this by the history of the case, if you will.

Don't fail to think of the possibility of every case being either syphilis or eczema; and

Don't fail to master these two diseases as thoroughly as possible; because, if you learn to recognize these two, you will have gone a long way in diagnosis. If they can be excluded, then the field of possible "might be's" is considerably narrowed.

Don't make the diagnosis of syphilis on account of a syphilitic history, because you can often get a history of syphilis in a non-syphilitic case.

Don't expect much, if any, history of syphilis in a woman, because you very frequently will not get it. This is not because they are "gay deceivers," but because in them the early symptoms of the disease are often so slight that they are not observed by them.

Don't throw out the diagnosis of syphilis on account of an eruption itching, because some syphilides, especially the papular variety, do itch at times. The *not* itching of an eruption is better presumptive evidence of syphilis than is itching positive evidence against it.

Don't make the diagnosis of lichen planus from the presence of flat angular papules with depressed centres alone, because identical lesions will at times be met with in eczema, syphilis, and psoriasis.

Don't depend upon getting the bleeding points springing out of the delicate pellicle after carefully scraping off the scales for your diagnosis of psoriasis, because you can produce the same thing in other diseases. In fact,

Don't depend upon any one symptom, but make your diagnosis from the general make-up of the disease as a whole.

Don't forget that many diseases of the skin are dependent upon disturbances in the general health of the patient. Therefore,

Don't fail to inquire into the performance of the

functions of the various organs of the patient, and to put him into as good a physical condition as possible.

Don't tell your patient that it is dangerous to cure his skin disease rapidly, because it is not. If you

Don't know how to treat the case, ask advice of some one who does.

Don't encourage the popular notion that there is danger of an eruption striking in, because it never does.

Don't give arsenic for every skin disease, and, especially,

Don't give it in acute eruptions. Its sphere is in the chronic scaly eruptions, such as chronic psoriasis.

Don't forget that most cases of pruritus are due to internal causes, and that in them external treatment is wasted; and

Don't forget the bed-bug and the pediculus as possible causes of the trouble.

Don't forget that the greatest secret in the treatment of eczema, and many other skin diseases, is not what particular drug or formula is "good for" the disease, but a knowledge of the great principle that acute diseases need soothing remedies, and subacute and chronic diseases need stimulation.

Don't expect to cure an inveterate eczema with thickened skin by means of a soothing ointment, such as that of the oxide of zinc, because you will only waste pour time, and the patient's money.

Don't use tar in an acute eczema, because it is a stimulant, and what we want at this time is to soothe the inflamed skin. It is appropriate to a subacute or chronic case.

Don't allow water to touch any form of eczema, because it always irritates in such a case.

Don't use a thick ointment on the hairy scalp, because it makes a disagreeable mess of the hair, and will not be "popular" with your patient. Even lard is not a pleasant vehicle for such applications. Vaseline and the oils are more elegant excipients.

Don't order the hair to be cut from the head of a young or old woman in any disease of the scalp, because, except in the case of a peculiarly stupid or careless patient, it is never necessary, and always disagreeable to the woman.

Don't allow a patient with ringworm to go to school, because if you do you will be responsible for the spread of the disease.

Don't pronounce a ringworm case well and incapable of spreading the contagion until you are sure that it is well; and

Don't be sure about it until there are no more "stumps" on the scalp, and you can find no more of the fungus in the hair.

Don't forget to caution a patient to whom you have given chrysarobin, not to touch his face with his hands after applying the drug, because if you do you will have either a mad or a frightened patient in your office.

Don't pronounce a patient addicted to the excessive use of alcoholic beverages on account of his having rosacea, because there are lots of other things besides alcohol that will cause it.

Don't use the name "barber's itch" for anything but trichophytosis barbæ, because it is well not to use terms loosely to cover several different diseases.

Don't use chrysarobin on the face or scalp, because it is very apt to cause a good deal of dermatitis with œdema, and to stain the skin a deep mahogany-red.

Don't use the positive pole of the battery for the needle in destroying hair by electrolysis, becaure if you do you will leave more or less permanent marks in the skin.

Don't apply a sulphur preparation after using a mercurial upon the face, or *vice versa*, because if you do you will raise a fine crop of comedones.

Don't use a camel's hair brush for making applications of corrosive sublimate, because if you do some of the salt will be left on the brush each time it is used, and you will soon have a stronger solution than you bargained for. Always use a little cotton on a wooden toothpick, or a splinter of wood.

Don't allow a fine-toothed comb to be used on the scalp, because it scratches and irritates the scalp.

Don't encourage or advise the use of pomades on the healthy scalp, because they are prone to become rancid, and inflame the scalp. They are also unnecessary if the hygiene of the scalp is properly looked after.

Don't forget that dandruff is the most frequent cause of premature baldness, because, if you remember this, you may be able to prevent the fall of someone's hair for some time. Therefore,

Don't fail to treat every case of dandruff.—Dr. Jackson, *in Med. Rec.*

THE MEDICINAL TREATMENT OF MENSTRUAL DISORDERS.

The treatment of symptoms alone, without regard to the underlying condition, of which the symptoms are but the expression, is often looked upon as unscientific and unworthy of the consideration of the true physician. It is, indeed, unscientific, and were it possible always to discover and remove the cause, it would be equally irrational and unjustifiable. But, unfortunately, we are unable always to act upon this principle. We cannot always discover the cause, and, knowing or suspecting it, we are often unable to remove it. This is noticeably so in regard to menstrual irregularities, especially as occurring in young women.

The general practitioner is often asked to relieve cases of this nature in girls who would never submit to an examination or operation, preferring rather to suffer pain indefinitely than the shame of a physical investigation into the nature of their trouble. In such cases the physician is forced to try the effect of medicinal agents, groping, it may be, in the dark, before insisting upon an examination. Such being the case, it is well to learn what remedies have been found to be of occasional service in relieving symptoms of this nature which are not dependent upon actual organic disease.

In a very practical paper, read before the Connecticut Medical Society, at its annual meeting in 1888, Dr. Gideon C. Segur, of Hartford, presents a general review of the subject, giving the results of his own experience, and quoting the opinions of several prominent gynecologists whom he has consulted. A brief *résumé* of these opinions is all that can be presented here, the reader who may desire a more extended presentation of the subject being referred to the original paper.

Amenorrhœa.—For this condition most of the authorities consulted recommended general tonics, iron, arsenic, and cod-liver oil. Permanganate of potassium, which was at one time so strongly recommended, does not seem to be in much favor, the objection to it being that it is too irritating to the stomach. Manganese was advised by some, and this is the remedy that the author has found to give the most satisfactory results. Most of the salts of this drug, however, cause so much gastric irritation that they cannot be used in most cases, but the binoxide seems to be an exception in this respect, Dr. Segur having used it in many cases with the happiest results, and without seeing any disagreeable effects caused by it. A disagreeable feature of this remedy, in Dr. Mundé's experience, though apparently not in the author's, was its unreliability. It might afford relief at one time, and yet at another, even in the same case, and seemingly under the same conditions, it would fail utterly to bring on the menstrual flow. The lactate of manganese is also free from the irritating action upon the stomach that most of the other salts of the drug exert. Manganese has the reputation of being an abortifacient, hence some caution is necessary in its use as an emmenagogue. But the maximum dose employed by the author is six grains a day, and this is far below that which has been used to produce abortion.

Dysmenorrhœa.—The opinions of the authorities consulted by the author concerning this symptom and its relief were most varied. Some thought no benefit could be obtained by any but operative measures, while others spoke hopefully of many remedies. Among those which seemed to have given most satisfaction to the writers were pulsatilla in three to five-drop doses three times a day; cannabis indica, viburnum, camphor, belladonna, and antipyrine. Dr. Segur found manganese to render good service in these cases also, in many instances. The binoxide was used in doses of six grains per diem. The application of heat, by means of the sitz bath, or douche, was a useful adjuvant to the internal medication.

Menorrhagia.—For this condition the most efficient remedies were found to be ergot, hydrastis, digitalis, sulphuric acid, fluid extract of gossypium, and gallic acid.

It is rather strange to find such a want of unanimity in the recommendations of these different authorities concerning the most efficacious medicinal agents for the relief of menstrual disorders. It is rather discouraging, also, as the number of remedies vaunted as useful in any particular trouble is generally an inverse proportion to its amenability to treatment. Yet, nothwithstanding the discouragements which those who attempt to treat menstrual disorders by drugs often encounter, the physician is many times powerless to treat them in any other way. Dr. Segur has, therefore, rendered good service in collecting the opinions of so many experienced gynecologists, and in giving the results of his own efforts to relieve sufferers of this class, and we hope that the paper will be useful to many who may perhaps be able occasionally to cure some of these disorders by one or other of the remedies mentioned by the author.—*Med. Rec.*

TUBERCULAR MENINGITIS CURED WITH IODOFORM OINTMENT.

Five cases of this disease were subjected to treatment of the kind mentioned in the title of the author's paper, and with gratifying results. Whatever errors there may have been in diagnosis, the author thinks it hardly possible that he could have erred in all five cases, though he admits that a differential diagnosis between tubercular meningitis and the less grave variety, during life, is very difficult. In all of the cases reported, the plan of treatment consisted in first shaving the hairy scalp and then rubbing in upon the skin a quantity of ointment composed of one part iodofor to five of vaseline, the head being then covered with a tarletan hood with an opening from the face. At each daily friction two grams of this ointment were used, and the treatment was continued from nine to thirty-two days. Moleschott first advised the use of iodoform for internal diseases in 1878, and he successfully treated three out of five cases of tubercular meningitis by applications of iodoform collodion to the scalp. Nillscez and Souders have also each reported a successful case of this disease treated in the same manner.

The author offers the following suggestions based upon his experience in this connection:

1. Iodoform which does not contain less than

96.7 per cent. of acid is nearly insoluble in water and in blood serum, and cannot penetrate the animal economy except through the medium of fatty substances with which it may be combined.

2. It is probable that when it is applied by friction it is received into the subcutaneous adipose tissue, which acts as a vehicle to its transmission. According to Binz, it is broken up, with the liberation of iodine, and this is absorbed and carried along by means of the organic fluids.

3. The iodine, in such cases, will act upon the protoplasm of the cells, both developing and destroying it.

4. This explanation will apply in regard to the treatment of tubercular meningitis by iodoform inunction; in accordance with which the free iodine would be carried by the lymphatics to the surface of the brain.

5. Whatever value be attached to any particular method of rubbing in the iodoform in tubercular meningitis in children, it would seem as if the subject were worthy of the serious attention of the profession.

6. Future experience may show that more rapid results may be obtained by some modification of this method than have thus far been reported. On the other hand, the prolonged use of iodoform is not followed by any accident.—*Arch. of Pediatrics.*

PARALYSIS.

Pilocarpin, gr. 1-10, subcutaneously, two or three times a week. In alcoholic paralysis.

℞. Extract nucis vomicæ, gr. v; ext. gentianæ, gr. 80. Divide into 20 pills, one night and morning. In alcoholic paralysis.

℞. Tinct. cantharidis, dr. iiss; tinct. nucis vomicæ, dr. iiss; aq. dest. ad., oz. ij. One teaspoonful night and morning. In paraplegia.

℞. Ext. ergotæ, fl. dr. iiss; aq. dest. ad., oz. ij. One teaspoonful three times a day. In congestive and menstrual paralysis.

℞. Phosphori, gr. ij; ol morrhuæ, oz. vj. One teaspoonful after each meal. In general paralysis.

℞. Liq. strychniæ P. B., dr. iss; syr. limonis, dr. ij; aq. dest. ad., oz. ij. One teaspoonful three times a day. In general and facial paralysis.

℞. Argenti nitratis, gr. vij; ext. nucis vomicæ, gr. xij. Divide into 24 pills, one after each meal. In locomotor ataxia.

℞. Argenti nitratis; ext. bellaeonnæ, āā gr. vij; ext. gentiaæ q. s. to make 24 pill. One after each meal. In locomotor ataxia.

℞. Tinct. ferri perchloridi; tinct. nucis vomicæ; acid. phosph. dil.; syr. simpl., āā oz. j. A teaspoonful in water before each meal. In hemiplegia and locomotor ataxia.

℞. Zinci phosphidi, gr. iv; ext. nucis vomicæ, gr. vi; ext. gentianæ, gr. xxiv. Divide into 12 pilis, one night and morning. In hysterical paralysis.

℞. Ext. physostigmatis, gr ij; ext. gentianæ, ℈ ij. Divide into 20 pills, one three times a day. In general paralysis, and paralysis of the insane.

℞. Potass. iodidi, gr. j; magnes. sulphat, dr. ij; aq. chloroformi, oz viij. Two tablespoonfuls night and morning. In lead paralysis.

Hyoscyamin, gr. 1-20, subcutaneously, once a day. In general paralysis of the insane.

℞. Sodii iodidi, dr. iiss; tinct. cinchon, dr. v; aq. des. ad., oz. viij. One tablespoonful three times a day. In paralysis following syphilis.—*Med. World.*

THE VALUE OF JABORANDI AND ITS ALKALOIDS IN THE TREATMENT OF BRIGHT'S DISEASE.—The patient was a man of nineteen, who for several months had suffered from some œdema, dyspnœa, and albuminurid. When seen he was propped up in bed, and dropsical from head to foot; his eyelids, which were distended with effusion, completely closed the eyes. His face was livid, and the swollen condition of the cellular tissues of the neck made it almost as broad as his shoulders. He coughed incessantly; there was copious intrathoracic effusion, and the subcutaneous tissue all over the chest was "doughy" to the touch. His abdomen was as big as a barrel, and there was extensive œdema of the genitals. His legs and thighs were enormously swollen, and water was exuding from them. He was passing a very small quantity of urine, which was of a dirty color and loaded with albumen. As a last resource, but without expecting much from it, I determined to try the subcutaneous injection of hydro-chlorate of pilocarpin, and the next day I gave two injections of a quarter of a grain each, one in the morning and the other late in the afternoon. After each dose I covered the patient thickly with blankets. The first effect was a flushing of the face, the saliva was secreted copiously, and within five minutes he broke out into a profuse perspiration. After the first injection he expressed himself as relieved, and he certainly coughed less. On my visiting him the next day, the lad's appearance was improved; he could see out of his eyes; he had passed a fair night, and the dyspnœa was lessened. I continued two injections daily for three or four days, and after each administration he sweated most profusely. I found he became very faint soon after the injection, and to counteract this I gave him a good dose of gin-and-water before the next one, and repeated this each time afterwards, when he never complained of faintness. Vomiting also occurred, once or twice severely, which induced me to lower the dose to one-fifth of

a grain, which I injected daily for nine or ten days. The improvement, which commenced early, was well maintained. At the end of a week he could sit up in bed, the cough was much less, the thoracic effusion had completely subsided, and his arms and neck were becoming less œdematous. The patient longed for my visits, and always expressed himself as feeling better after a "jolly good sweat." At the end of a fortnight his upper parts were free from effusion, but the abdomen was still much distended, and I hardly believed that we could get rid of an accumulation which at one time threatened to rupture the skin, and which it seemed that nothing but tapping would relieve. I then administered one-fifth of a grain on alternate days, and kept this up for another fortnight. He was then passing his usual quantity of urine, the albumen much diminished in quantity; he sat up daily by the fire, and there remained but a little swelling of the abdomen and legs. I continued the injection till the remaining dropsy had subsided. The improvement was maintained, and under a diet of plenty of milk and the administration of iron and convallaria majalis, he was able to go out of doors and enjoy life with comfort.—*Lancet.*

MECHANICAL TREATMENT OF TABES DORSALIS.—A singular method of treating cases of locomotor ataxy has, during the past three months, been tried at the Salpétrière, and the results have been so satisfactory that M. Charcot recently devoted one of his lectures (*Progrès Médical*, Jan. 19th) to the subject, demonstrating the cases so dealt with. The practice is not absolutely novel, since, in 1883, it was brought forward by Motchoukowsky, of Odessa, who claimed that twelve tabetics had been greatly benefited by it, and also that the plan was of use in cases of sexual impotency apart from tabes. Last year, M. Raymond, when on a visit to Russia, heard of the practice, and introduced it to M. Charcot's notice, and, as above said, it has been adopted in M. Charcot's wards during the past three months, the "chef de clinique," M. Gilles de la Tourette, superintending it. It simply consists in suspending the patient by means of Sayre's "jury-mast" for a period beginning with a duration of half a minute and progressively increasing up to three or at the most four minutes, an interval of two days occurring between each suspension. In order to exert greater traction on the spinal column, it is well to raise the arms every fifteen or twenty seconds. Eighteen tabetics have thus been treated, embracing about 400 "suspensions." Excluding four who were not suspended more than three times, the improvement was marked in fourteen, and eight of these most remarkably. They were all confirmed cases, and had mostly been treated by cauterisation along the spine. Almost from the commencement of the suspension treatment the patients would improve in walking—an improvement at first temporary, but after eight or ten suspensions becoming continuous. They could then stand more easily, and walk without assistance. After twenty or thirty suspensions Romberg's symptom disappeared. There was also relief from vesical troubles, when these existed; diminution and even disappearance of lightning pains; return of sexual desire and capacity. Anæsthetic and other sensory disturbances also disappeared, and the general condition of the patient improved, sleep being better, etc One case had a return of lightning pains whilst being treated, but, subsequently, again underwent improvement, which in all the rest was uninterrupted. In no case did the knee-jerk return, or the pupil reaction become normal. The method has also been applied to a few non-tabetic cases, as Frederich's disease, neurasthenia, and disseminated sclerosis; but, as M. Charcot observes, the method is still in the experimental stage. So far the results in tabes are encouraging, whilst the simplicity and harmlessness of the method are additional recommendations for its further trial.—*Lancet.*

THE USE OF ALCOHOL IN MEDICINE.—According to Professor Binz, of Bonn, alcohol in small doses increases the arterial pressure; in large doses the opposite effect is produced. Alcohol increases the activity of the left ventricle of the heart, and diminishes the moments of rest, and increases the respiration. Alcohol in moderate doses is eliminated by the lungs and kidneys. Alcohol burns up into carbonic acid gas, and water taken into the system. This action produces heat, and is of value to temporarily stimulate and strengthen the system. Alcohol does not increase oxidation. Only such substances can be rightly considered as nutritives which promote the heat of the body without producing any injurious accompanying symptoms. It is known that alcohol in large doses increases the decomposition of albumen, and hence, in many cases of severe illness, tends to hasten the fatal result rather than retard it Alcohol has the power to reduce the temperature of the body in certain conditions. Moderate doses which do not produce the least symptoms of intoxication, will cause a fall in temperature of several degrees. The habitual use of alcohol deadens the heat-reducing property until it becomes no longer observable. Narcotic doses of alcohol reduce the temperature several degrees, and this reduction remains for several hours. All the causes of this fall of temperature are not understood. One of them is an enlargement of blood vessels of the skin, and an increased radiation of heat. Alcohol seems to be a drug of great value in therapeutics, but it must be given with great discrimination. In a healthy man it is always an

injurious drug. A habitual beer-drinker is as much an alcoholist as a habitual whiskey-drinker. It is the duty of physicians to support every effort to break up the indiscriminate use of alcohol as a beverage or medicine, and insist that it be used with therapeutical precision. These views were sustained by the members of the congress, and a general agreement was reached that all possible caution should be observed in the use of alcohol as a medicine, and its changing effects on different individuals.—*Therap. Gaz.*

DIABETES MELLITUS.—Professor Seegen distinguishes two forms of diabetes; the one light, in which sugar is found in the urine only when the patient ingests starchy food; the other graver, in which sugar is found, even when the patient completely abstains from the latter diet. The first form is met with as a rule in advanced life, while the graver variety attacks young and middle aged persons. The following table by Seegen, records the age at which diabetes presented itself in eight hundred cases:

In 5	per cent.	between	the ages of	1 and 10	years.
" 3	"	"	"	10 and 20	"
" 16	"	"	"	20 and 30	"
" 24	"	"	"	30 and 40	"
" 30	"	"	"	50 and 60	"
" 10	"	"	"	60 and 70	"

He has met the disease more frequently in men than in women, the proportion being as 7 to 3. The duration of the graver form is generally from four to five years. The mild form lasts from ten to twenty-five years. In the majority of cases (ninety per cent.) the nervous system is in an abnormal condition. The prognosis may be determined as follows: grst examine the urine, and prescribe an exclusively animal diet for two days, then examine the urine again. If on the second examination no sugar is found, the diaease is of the mild form; if, however, traces of sugar appear, the disease is more serious. Seegen has never observed an absolute cure in 800 cases; *i. e.*, when an experimental amylaceous diet will not yield sugar in the urine. In the mild form of diabetes, alkaline waters have a favorable action on the elimination of sugar, which lasts for some time after their disuse. In grave cases the alkaline waters and animal diet are of no value. Morphine and codeine have only a temporary action. The elimination of sugar according to this writer is, in the light form, due to the hepatic cells which have lost the property of acting on starchy foods. In the grave form, sugar is eliminated, although the patient may not have ingested amylaceous food, because the combustion of the hydro-carbon does not take place.—*Boston Med. and Surg. Jour*

WATER DILUTION OF THE BROMIDES IN EPILEPSY.—Since Hughes (*Med. Standard*) first began prescribing the bromides in epilepsy, he has been in the habit of ordering that each dose be taken in a glass of water or milk. This obviates gastric irritability, promotes rapid absorption, and prevents undue concentration of the blood, a determining factor in the production of the epileptic paroxysm. Novi showed that spasm of the vessels, due to cerebral stimulation, resulted when the density of the blood became double that of the normal, a state brought about by the intra-venous injection of a ten per cent. salt solution. Hughes believes that the above physiological fact may aid in the explanation and treatment of idiopathic epilepsy and of eclampsia. The influence of warm baths, of enemata, and of copious draughts of warm water, over infantile convulsions, Hughes thinks would thus seem to find a rational explanation. He regards it probable "that the thickening of the blood, drained of the serum, has the same effect upon the motor centres of the muscles as sudden anæmia and withdrawal of arterial and arteriole pressure, such as is displayed in the convulsions of decapitated animals and in the cadaveric rigidity which appears when the blood forsakes the arterial channel for the venous." Dilution of the remedies given in epilepsy would seem to be indicated to thin the blood, and diminish vaso-motor irritability, and conseqent tendency to vascular spasm. —*The Polyclinic.*

ON THE DILATATION OF THE PUPIL IN LOCOMOTOR ATAXY.—I have several times observed a dilatation of the pupil in cases of locomotor ataxy in which the pupil did not contract to light. This dilatation only occurs, according to my observations, when the light employed in the search for the Argyll-Robertson symptom is intense, such a light as that used in the ophthalmoscope room. My impression has been that it is the intense light and heat acting upon the conjunctiva—i.e., fifth nerve—which is the cause of the dilatation of the pupil, just as is supposed to happen in stimulation of the skin of the neck by pinching, or by the faradaic brush. But the dilatation due to intense light and heat is very small compared with that which usually obtains in health on irritating the skin. In the case of locomotor ataxy in which this dilatation of the pupil has been witnessed, pinching the skin of the neck on the side on which dilatation occurred from exposure to strong light and heat only caused a slight dilatation of the pupil. The pupils contracted when the eyeballs were convergent. It would be interesting to know whether the great heat of the lamp had as much to do with the production of the phenomenon as the intense light. In the cases in which I have observed this dilatation, the pupils have not been very small.—Angel Money, M.D., in *Lancet.*

STRYCHNINE IN DELIRIUM TREMENS.—Large

doses of strychnine are being used in delirium tremens and alcoholism, with a success that renders the promoters of the method enthusiastic. (*Boston Med. and Surg. Journal.*) The originator, Luton, of Rheims, gives as high as a twelfth of a grain two or three times a day by mouth or subcutaneously. Dujardin-Beaumetz reports uniformaly good results from the practice. No toxic effects are produced, but a marked benefit ensues. The insomnia, agitation and delirium severally disappear. Sleep was in some instances induced, after all other hypnotics had failed. The "why and wherefore" of this new method of combatting alcoholic delirium is thus explained by Dr. Ramos, of Brazil: "I believe with M. Luton that in chronic alcoholism there is inertia of the excito-motor properties of the spinal cord, which enables the patient to tolerate large doses of strychnine. In these cases the strychnine has a substitutive action on the nerve centres, antagonizing the excitant action of the alcohol."

THE TREATMENT OF RICKETS should be by food rather than by drugs. Raw meat is of more value than iron, and cream or fresh milk than cod-liver oil. The diet must be carefully examined to see that it contains a due proportion of fat, proteids and salts. A sufficiently close estimate is easily made, since the composition of milk and of all foods used for children is accurately known. The amount of animal fat in a rickety child's food must equal at least one-fourth of the total sollids taken; proteids and carbohydrates about one-third, and salts about one-tenth. Such a diet will cure rickets without drugs. Iron is often a useful adjunct. The salts of lime may be added in the form of lacto-phosphate. Potent aids are sunlight, fresh air, and warm clothing.—*Lancet.*

ETIOLOGY OF PUERPERAL FEVER.—At the Medical and Chirurgical Society, of London, Dr. W. R. Smith read a paper on "The Etiology of Puerperal Fever," based on some researches carried on at the Brown Institution. Blood was obtained from the heart of a patient who had died from puerperal fever, and cultivations made on gelatine in the usual way. Blood was also obtained from the finger of a woman suffering from puerperal fever, and similar cultivation-experiments made. As the result of numerous observations, Dr. Smith had found that a micro-organism occurred in the blood of persons affected with puerperal septicæmia in considerable numbers in the form of streptococci. Culturally there were marked differences between it and other streptococci. Its action on mice was distinct and definite, and it could be distinctly distinguished from the erysipelas streptococcus of Fehleisen, and from the streptococcus pyogenes Rosenbach. An animated discussion followed the reading of the paper.—Correspondent, *Med. Rec.*

ANÆSTHETICS IN LABOR.—The ethical question, How far is it pusillanimous and even irreligious to profit by the annihilation of pain which anæsthesia affords under surgical operation, and in parturition? has recently undergone discussion anew in some of the French papers. The discussion is antiquated and out of date in this country, and many of the stories told would hardly bear repetition in this serious country. Sir James Simpson long ago disposed of the argument now revivified, which charges the woman who accepts anæsthesia in childbirth with evading the biblical injunction of pain. An indignant French-woman has revived an old argument with some flippancy, but not without a reckless wit. "You quote," she says, "some verses of the Bible against us; but let me remind you that the only one of your sex who took his part in the act of giving birth profited by anæsthesia; for when Adam gave up a rib toward the creation of Eve, he was first thrown into the deep sleep of insensibility."—*Br. Med. Jour.*

DANGERS OF BLISTERING IN CARDIAC DISEASE — Professor Jaccoud, of Paris, calls the special attention of practitioners to the contra-indications to the employment of flying blisters in certain cases of disease of the heart. The important point, according to this distinguished authority, is to ascertain the state of the kidneys in these subjects. In case there be discovered in the urine even the smallest trace of albumen, the use of blisters to the præcordium ought to be rigorously proscribed. Neglect of this rule has led to the unwitting aggravation of the patient in many instances. Sometimes ignorance has been the cause, sometimes imperfect testing, at other times culpable temerity—which has made light of the presence of albumen while a blister was being prescribed. It is easy to substitute iodine paint to the præcordium if cantharides be contra-indicated.—*The Practitioner.*

A VERY fine exhibit was made at the American Institute by the Jerome Kidder Manufacturing Company, 820 Broadway, New York, makers of Dr. Kidder's electro-medical apparatus. The company may well take pride in their exceptionally fine line of instruments, medical batteries, etc. The company have received the highest awards from the Institute since 1872, and so far from falling off in their productions, manifest a steady onward and upward tendency. They show a full line of galvanic batteries, galvano-caustic batteries, many styles of faradiac batteries for family and physicians' use, tip batteries, surgical instruments, cauteries and special appliances for and endless variety of medical and surgical operations.—*Electrical World.*

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ABORTIONISTS.

Although little is said concerning the prevalence of abortionists in cities and towns, not to say villages, yet their presence cannot unfortunately be denied. It is pretty generally known, not only to the profession, but to the laity, that these criminals practise their nefarious trade among us with comparative impunity. Occasionally the subsequent dangerous illness or death of these unnatural mothers, exposes the abortionist to the perils of the law, and he or she is convicted, and suffers the legal penalty of the crime. But we are convinced that exposure and conviction are very rare exceptions, and that the great majority escape any punishment, and continue to extort large incomes from those who have fallen from virtue, and from more inhuman married women, who wish to be relieved of the care and trouble of raising their offspring. We are of opinion that this sad condition of affairs could not obtain so largely, were the community not generally tolerant, and the public apathetic. Indeed, we fear that even members of the profession ignore their duties in this respect, and often neglect to assist in bringing upon abortionists the legal consequences of their crime, sometimes becoming *particeps criminis*, by concealing their knowledge from the authorities, in order to avoid an exposure of the fair sinner, and prevent her family from suffering from the scandal necessarily consequent. Indeed, it is possible that the powers that be, do not always put forth as much effort as they might, to secure the suppression of abortionists, on account of social consequences to those entirely innocent. Hence the abortionist often goes unwhipped of justice.

That this indifference, this apathy of the community in general is largely responsible for the existence of abortionists, and the demand for their crime cannot be questioned. Of the immorality and deplorable results consequent upon this growing murder of the innocents, it may not be our province to speak; yet, as citizens, we should possess an interest in suppressing so heinous a crime, and, as medical men, we are in a position to know more of its prevalence and demoralizing tendencies than others. Hence the question whether professional secrecy should be extended to a crime of so vicious a character. The law justly considers it a capital offence, with a penalty attached little less than that of murder or homicide. Therefore, the medical man can hardly be guiltless who assists in defeating the ends of justice by suppressing his knowledge of the crime and criminals.

But we know it to be injurious and often dangerous to ourselves. What physician, in practice for any length of time, has not had many applications, often accompanied by a considerable bribe, to relieve the victim of the seducer from the social disgrace attached to her sin, or the selfish and degraded married female from the care and trouble naturally devolving on her? It is to the credit of the profession that so few have fallen victims to so alluring a temptation, especially the younger members, to whom these applications are more frequently made when patients and fees are often extremely rare. But if he politely but distinctly refuses to become an abortionist, either for sympathy or lucre, he often secures the enmity of the applicant and her friends, and is sometimes charged with the very crime he refused to commit, and, it may be, put to the annoyance and expense of defending a criminal lawsuit where the difficulties of successfully defending himself are obviously great; and, though he succeeds, he is often injured financially and socially, and his practice among the community in that vicinity largely destroyed. This is no imaginary picture. Numerous instances could be mentioned where false charges of this nature have been made, possibly to screen the

actual criminals, or to gratify the resentment of those on whom exposure has fallen through the abortionist's mismanagement and the subsequent illness or death of his victim, on whom the medical man had declined to operate. Indeed, more than one instance could be quoted where innocent physicians have committed suicide from the mental worry and distress caused by false charges of this character. Therefore, in our interests and for the credit of the profession, if upon no higher ground, we should exert every effort to bring these odious excrescences upon our body professional to justice. The difficulties of obtaining sufficient evidence are great, but not insuperable. Were we to adopt the course of informing some competent executor of the law, of each criminal application of this nature made to us, to be acted on or otherwise as circumstances might demand, such applications would soon cease and the temptation and danger incurred to medical men obviated. The professional abortionist would soon find more difficulty in evading the laws made and provided in our penal statutes. A much healthier public opinion would obtain, and the detestable practice would be regarded with greater abhorrence. Hence the difficulty of obtaining sufficient evidence in these cases would be largely diminished, and not only would the crime be lessened, but also, in many instances, demand for abortion might be obviated on account of stronger motives inspired to resist the wiles of the libertine. That this sin of the age prevails so largely among civilized nations is a disgrace to the boasted cultivation and morality of the present century, and one whose demoralizing and pernicious influences can hardly be computed.

INFANTILE CONVULSIONS.

In a paper on the above subject by Dr. J. N, Love, of St. Louis, he emphasizes the following points *(Weekly Med. Rev.)*:

1. We must not lose sight of the fact that a convulsion is only a symptom and not a disease. We must promptly determine the cause and then intelligently and energetically eliminate it. 2. We can probably classify the majority of cases of infantile convulsions as being caused by ill-fed nerve centres (rachitics and victims of tuberculosis), reflex irritations and cerebro-spinal engorgements and congestions dependent upon the high temperatures incident to the poisons of malaria, the infectious diseases and narcotics. 3. As we can make a triple classification in the etiology, it follows that we should have a similar division in the matter of treatment, and succinctly stated we may designate the latter as (*a*) nutritive and constructive, (*b*) a removal of all irritation from the sympathetic system, (*c*) antiphlogistic eliminature, cooling and sedative. 4. While calming the fears of the agonized parents, whose child is taken with a spasm, by assurances that an infant rarely dies in this manner, and that causes, the most insignificant sometimes, occasion the disturbance, we should not fail to impress them with the fact that it is a serious matter, and that the best possible way to treat the convulsive diathesis is a perfect hygienic regime, prevention by good food, proper clothing, fresh air and sunshine, plenty of sleep and avoidance of all excitement. 5. On discovering a child in an eclamptic paroxysm, no one article is more essential to a proper examination than a well tested thermometer (it being practically the doctor's sixth sense which enables him to go far toward making a diagnosis), and the only proper place for locating it, in ascertaining the degree of fever, is the rectum, leaving it *in situ* not less than three minutes. 6. For the prompt quelling of a spasm, chloroform by inhalation is a most valuable remedy, but it should be used carefully and not too early, as it may serve as an agent to mask the true condition of the patient, the hiding of the danger signal kindly thrown out by Dame Nature. 7. In the cooling bath we have a prompt and potent means for quelling the riotous condition of the cerebro-spinal system, not the sudden ice-cold, bath as that borders on the brutal, but the water in the beginning, about the temperature of the patient, and gradually reduced to 70° or 60° Fahrenheit, and possibly lower, if the indications call for it. 8. In acetanilid I am sure we have a most valuable remedy for the relief and prevention of convulsions. Clinical experience for one year justifies the conclusion. The action of the drug is rapid, usually beginning to manifest itself within an hour, and not infrequently within twenty minutes, its full effect reached in four hours. Pulse and respiration are slowed, arterial tension rises, diuresis and diaphoresis occur, pain is relieved and sleep usually ensues. No very great amount of depression

follows, if given carefully, but an exanthematous rash now and then accompanies its administration.

In confirmation of my own experience of its value in the convulsive diathesis, I note the fact that Dr. H. N. Mayer, in the *London Med. Rec.*, of Aug. 20, 1888, reports favorably on its use in epilepsy, five grain doses three times daily.

COLOR BLINDNESS.

"Mocking the air with colors idly spread,"

May be said to be the unfortunate condition of the color blind. In the year 1777, the first case of color blindness, that of the shoemaker, Harris, of Maryport, in Cumberland, was described by a Mr. Huddart. A few years later, Dalton described his own sensations. Three-quarters of a century elapsed before another Englishman attempted a scientific investigation of the subject; this was Professor Wilson, of Edinburgh. But it is to Professor Holungun, of Upsala, Sweden, that we are indebted for producing a practical system of investigation. His work was published in 1871, nearly a hundred years after the publication of shoemaker Harris' case.

The invention of steam engines and railroads gave color blindness an importance that it otherwise might not have had, inasmuch as the necessity for signalling caused the use of colored lights and flags. Then it was found that there were those who could not distinguish the color of them. Experience has proved that color blindness is incurable, and the greatest good that can accrue to a color blind is to know that his color sense is defective early in life, and by accustoming the eye to the sensations of color, and the ear to the names, the power of distinguishing color tone is increased, though color itself cannot be appreciated as by the normal eyed.

This being the case, the importance of a careful elimination of the color blind from among railway employees can hardly be over-estimated. It will easily be understood that mistaking the danger signal for the safety signal may involve great loss of life and money. That such an event has occurred is incontestible. In most countries, the examination of railway employees is controlled by law. In this country, the companies use their own discretion in the matter. The examinations are conducted by the superintendents of divisions. In our opinion, the examinations should be controlled by experts who have made the color sense and color blindness a special study. If necessary, legislation should be obtained to accomplish this object.

Public attention has recently been called to this subject by Professor Ryerson, in a paper read at the Canadian Institute.

NOTES AND OBSERVATIONS

FROM NEW YORK HOSPITALS AND SOCIETIES.

For the relief of those obstinate cases of chorea in which arsenic has been tried and failed, Prof. Janeway strongly advises the use of Hyoscyamine in doses of $\frac{1}{120}$ grain three times a day. In many cases he has seen almost miraculous results, the choreic movements being controlled entirely.

In cases of anteflexion, Prof. Thomas no longer recommends the use of pessaries; and New York Gynecologists, in accordance with modern uterine pathology, have almost discarded the use of pessaries. His treatment is as follows: after thorough douching of the vagina with bichloride, he introduces Ehlinger's dilators and thoroughly opens the cervical canal, great care being taken to dilate the internal os. Then the uterine cavity is douched, the anteflexion corrected by means of a sound, a perforated glass cervical stem introduced and left in position. It is not necessary to remove it during menstruation, but on any suspicion of pregnancy it should at once be removed. It will be remembered by all who have read his work on Diseases of Women, that he relates that this procedure is frequently followed by peritonitis and is to be regarded as dangerous. He explains this by stating that it is now nearly ten years since he has revised his book, and it was written before the days of antiseptic gynecology, and by strict antiseptics it is found that this plan is unattended with danger. Prof. Thomas states that he now has numerous patients, some of whom have travelled all through Europe wearing these glass stems, and none have complained of any ill symptoms, and the relief obtained, in some cases, all that could be desired.

The lack of advantages in New York for the proper study of gross pathology has long been felt; heretofore, the drawback has been a proper place

for the performance of autopsies, and the concentration of them. This is to be obviated by the erection of a suitable post-mortem building adjoining the city morgue at Bellevue Hospital, where, it is understood, every convenience will be supplied and courses given similar to those in the European medical centres. The advantages for microscopic work in New York are unsurpassed anywhere, all of the medical colleges have magnificent laboratories, so that this addition will be a welcome boon to student pathologists.

Creolin is the latest antiseptic and it has been given an extensive trial. The ordinary strength used in surgical operations is 1 per cent.; it makes a milky looking emulsion. It is used in all cases where bichloride or carbolic are applicable, and is supposed to have the property of checking capillary hemorrhage, besides being an excellent antiseptic and deodorant. As a deodorant it has given good results in fetid discharges as in carcinoma uteri, etc. As a general antiseptic it does not appear destined to become very popular, but by experiment it is found that a few drops of a three per cent. solution completely destroyed the cholera bacillus, so that it may prove of use in the treatment of Asiatic cholera. It has also been tried in the diarrhœa of phthisis, dose five ounces three times a day, with very favorable results.

INCREASED MORTALITY FROM CANCER.—In the Morton lectures delivered by Sir Spencer Wells, he said: "Notwithstanding the great advance in sanitary science and the prolongation of the average length of human life—in spite of the shortening of the duration and the lowering of the mortality of some diseases, the prevention (almost the stamping out) of others—cancerous diseases, so far from being less prevalent or less fatal, are increasing among us. The increase in the number of deaths from cancer is now, and has been for many years past, greater than the proportional increase of population." And he proved conclusively that this increase is common not only to England and Wales, and in Scotland to nearly the same extent, but also in Ireland, though in smaller proportion. The correspondence between the Collective Investigation Committee of the British Medical Association and the Registrar-General will not be forgotten, and its importance was fully acknowledged by Sir Spencer Wells. The facts that the number of deaths from cancer in England had increased from 7,245 in 1861 to 17,113 in 1887, and that the proportion of deaths from cancer to one million persons living had increased from 360 in 1861 to 606 in 1887 in England; in Ireland from 350 in 1877 to 430 in 1887; and in Scotland from 404 in 1861-65 to 540 in 1881-85, are surely of extreme importance. They will probably surprise most of our readers. They have never before been so clearly put before us as in the second Morton lecture.

INEBRIETY.—In a paper recently read on this subject, before the Medical Jurisprudence Society, Philadelphia, Dr. Parrish summarises *(Polyclinic)* as follows:

1. Alcoholic inebriety is a disease which chiefly affects the nervous system, and may be transmitted from one generation to another, or it may be created by long continued indulgence, and render its victims as much slaves to its power as if inherited.

2 In either case the symptoms are the same, and the person is debauched at intervals of varying duration, being controlled by an impulse which is beyond the reach of human will.

3. When committing a criminal act, is is usually done in a state of unconsciousness and irresponsibility.

4. If convicted of crime, he should be isolated from the community in a hospital or asylum provided by the State.

5. The dangerous element of the disease is in the fact that when alcohol enters into the human body in excess, it assails the inhibitory power, controls the will, and enslaves its victim beyond his power of choice.

ACTION OF ALCOHOL ON THE HEART.—Dr. Richardson writes (*Jour. of Inebriety*) on the above subject as follows:

"Although the primary effect of alcohol is on the nervous system, the first organ to bear witness to that effect is the heart. The pulse requires three days to regain its normal condition after complete intoxication. In the inebriate the heart is never normal in its action. At first it is made tense and full. In continued inebriety this extends to permanent enlargement, dilatation, with stretching of

the valves, and distension of the whole arterial system. Then comes modification of structure. The heart is large, dilated, the arteries rigid, the veins bulging. In the major form of inebriety two to six years are necessary to restore the circulatory organs to something of their normal condition.

THE TREATMENT OF DIPHTHERIA WITH INSUFFLATIONS OF SUGAR.—C. Lorey *(Deutsch. med. Wochenschr., Am. Jour. of Med. Science)* highly recommends the treatment of diphtheria by the insufflation of very finely powdered sugar upon the tonsils, pharynx, posterior nares, the entrance to the larynx, and, after tracheotomy, through the canula. As a result of careful observation on eighty cases of diphtheria of all forms, and at all ages, he concludes that under this treatment the duration and extent of the diphtheritic deposit, and the danger of general infection can be lessened. The odor of decomposition also disappears, the mucous membrane of the tonsils and pharynx becomes more natural in appearance, and is coated with an abundant mucous secretion, and the false membrane softens and becomes detached. In many cases in which the larynx was involved, the insufflation loosened the cough and the threatening symptoms gradually ceased. The favorable action of sugar on unhealthy granulations has long been recognized. In the pharynx, the fine particles of sugar penetrate into the mucous membrane and cause a flow of its secretion toward the surface, loosening the membrane, and perhaps washing away the micro-organisms. General treatment is, of course, to be employed also, and for this purpose the author prefers apomorphia, and later, an easily digested iron preparation.

SALICYLIC ACID AND ITS SALTS.—W. A. Cauldwell, M. D., Chicago, in discussing the rational selection of the salts of salicylic acid (*Gaillard's Med. Jour.*), says they are insoluble in the acid gastric juice, but in the duodenum they are split up into carbolic and salicylic acids. Some of its various uses are: 1. To remove certain morbid materials from the system. 2. To act as an antiseptic in the intestinal canal. 3. To act as an antiseptic in cystitis and pyelitis. 4. To act as an antiseptic in the treatment of wounds, ulcers, etc. Salicylate of bismuth is of great service, given in half drachm doses every two hours in inflammatory affections of the gastro-intestinal tract. It is astringent and antiseptic, arresting fermentation, and is good in diarrhœa of phthisis and typhoid, cholera morbus, dysentery, and dyspepsia with acid eructations. Salicylate of magnesium is useful in enteric fever, diminishing the swelling of the abdomen, and removing the septic material from the intestinal canal, as it is not astringent.

PUERPERAL ECLAMPSIA.—Dr. Auvord's work on puerperal eclampsia *(Bull. d'Acad. de Méd.)* has the following statement as to the result of various methods of treatment adopted in this disease:

I. *Mortality of Mothers.*

1. Purgatives	43	per cent.
2. Forceps	42	"
3. Bleeding	35	"
4. Chloroform and chloral	34	"
5. Version and delivery	38	"
6. Preventive milk diet	28	"

II. *Mortality of Infants.*

1. Version and delivery	57	per cent.
2. Bleeding	53	"
3. Forceps	40	"
4. Purgatives	37	"
5. Chloroform and chloral	27	"
6. Preventive milk diet	21	"

BITARTRATE OF POTASH IN PUERPERAL ECLAMPSIA AND BRIGHT'S DISEASE.—Dr. Edward Anderson writing to the *Maryland Med. Jour.* says of a former letter to that journal, recommending pot. bitart. in the above affections: "I am glad to see what I therein stated endorsed by the Gynecological and Obsterical Society of Baltimore, at its meeting Dec. 11, 1888. The bitartrate will not only prevent convulsions from occurring during pregnancy but will also prevent their occurrence in Bright's disease and in albuminuria following scarlet fever. I treated a farmer, the subject of Bright's disease, for seven years, and kept him tolerably comfortable up to within three months of his death by administering the bitartrate of potash to him whenever his urine became loaded with albumen; he performed hard labor all the time."

SPECIFIC GONORRHŒA IN FEMALES.—Gonorrhœa in the female can be speedily cured, when the

disease is confined to the vagina, by vigorous use of hot-water injections and warm hip baths in the acute stage, and injection of bichloride solution, 1 to 1,000, after the acute stage has subsided. The corrosive sublimate solution should never be used in the acute stage of specific gonorrhœa, but after the acute inflammation has subsided it should be used copiously every few hours till cure is obtained. Perfect quiet is necessary in the acute stage, and is also beneficial in the chronic. Tampons of hydronaphthol and glycerine may also be employed with benefit.

OINTMENT FOR FURUNCLES. — *L'Union Méd.* says, that an ointment composed of 1½ grs. red precipitate to ½ an ounce of vaseline, is an excellent application for furuncles. If a stye is to be treated, apply the ointment over the affected part and rub gently. In some persons with a delicate skin, the red precipitate may require to be reduced to ¾ or ½ a grain. A single application is said to arrest small furuncles. When they are large, several applications made the same day will effect a cure.

THE BEST TWENTY-FIVE DRUGS.—The following list says the *Med. Rec.* has been suggested as representing the "soul of the pharmacopœia": 1, opium; 2, mercury; 3, iodides; 4, quinine; 5, chloroform; 6, ether; 7, sulphate of magnesia; 8, salicylic acid; 9, aloes; 10 alcohol; 11, bromides; 12, iron; 13, chloral; 14, castor oil; 15, digitalis; 16, arsenic; 17, colchicum; 18, ipecac.; 19, aconite; 20, strychnia; 21, cocaine; 22, ergot; 23, bicarbonate of potash; 24, mineral acids; 25, nitrites.

NIGHT SWEATS.—Few practitioners, says *Technics*, appreciate the exceedingly great value of agaricin as a remedy in night sweats, especially those of phthisis. The most profuse sweat is checked almost like magic, with a single dose. It operates by diminishing thirst and increasing the secretion of urine. The dose may be pushed to the extent of one grain in the course of twenty-four hours. The single dose for an adult is from one-eighth to one-fourth of a grain.

NEW LOCAL ANÆSTHETIC.—A new local anæsthetic, HAYAP, was lately presented at a meeting of the Berlin Medical Society. It was brought from Africa in a reddish mass. An aqueous solution caused in fifteen minutes after its instillation into the eye, complete anæsthesia, which lasted from ten to twenty-four hours.

ANTIFEBRIN.—Dr. Theodore Cash, F.R.S., Professor of Therapeutics in Aberdeen University, says, antifebrin is "an antipyretic of the first order," and to be preferred to antipyrin on the following grounds: 1. The smaller dose in which it is operative. 2. The steadier and more continued action. 3. The comparative freedom from danger of causing collapse. 4. Its cheapness, being purchasable in the open market. Its drawbacks are its insolubility and its tendency, to produce in time anæmia, which, however, is very amenable to treatment.

PERNICIOUS ANÆMIA.—Dr. Henry Walds recommends (*Br. Med. Jour.*) B-napthol in three grain doses every four hours in pernicious anæmia. Dr. William Hunter, he says, concluded after a long and careful investigation that the disease is extensive blood destruction, caused by the action of certain poisonous agents, probably of a cadaveric nature absorbed from the intestines.

INOCULATION OF CANCER.—There is reason to believe that recurrence of cancer may be due to accidental inoculation. Prof. Hahn lately engrafted three portions of skin, infiltrated by cancer upon the opposite breast of a patient suffering from cancer. Shortly afterwards when she died, examination of the breast upon which the grafting had been done, showed cancerous elements present.

CHOREA.—The following is an excellent formula for chorea:

R.—Ac. Arseniosi, ... gr. ij.
Strychniæ sulph, . . . gr. iv.
Fer. et. ammon. cit., . . gr. xx.
M.—Et. divide in pil. xx.

S.—One three times a day, after meals.

THE HOG AHEAD.—The *Med. Rec.* says, it is stated that the United States Government has paid more money for the investigation of diseases of the hog, than for all the diseases affecting the human race.

Boils.—Those persons troubled with successive crops of boils, should resort to 6 to 10 drops of Fowler's solution of arsenic three times daily. Turpentine in same doses is often an efficient remedy. Warts are said to be removed by the same doses of arsenic solution in a short time.

The following prescription is recommended in anæmic and poorly nourished patients suffering from rheumatism :

℞.—Sodii salicylatis, ... ʒ iv.
Glycerini, ... ʒ ij.
Ol. gaultheriæ, ... ♏ xx.
Tr. ferri chloridi, ... ʒ iv.
Acidi citrici, ... gr. x.
Liq. ammonii citratis, ad., . ʒ iv.—M.
Sig.—ʒj several times a day.

The first triennial prize of two hundred and fifty dollars under the deed of trust of Mrs. W. F. Jenks, has been awarded by the Prize Committee of the College of Physicians of Philadelphia, to John Strahan, M.D., M.Ch., M.A.O. (Royal University, Ireland,) 247 North Queen St., Belfast, Ireland, for the best essay on "The Diagnosis and Treatment of Extra-Uterine Pregnancy." The writers of the unsuccessful essays can have them returned to any address they may name, by sending it and the motto which distinguished the essay, to Ellwood Wilson, M. D., College of Physicians, Philadelphia.

Dietetic Notes.—We would call the attention of our readers to the advertisement of the Lambert Pharmaceutical Co., of St. Louis, to be found on page 5. This Company has had prepared Dietetic Notes, suggesting the articles of food to be allowed and prohibited in several diseases in which their Lithiated Hydrangea has proven of special service. A neatly bound book of these dietetic notes, each note perforated for the convenience of physicians in detaching and distributing their patients, will be sent free of cost; together with an illustrated treatise upon Catarrh and other monographs of more than ordinary interest bearing upon the value of Listerine in the internal and external antiseptic treatment of disease.

Ministerial Risk.—"I'm very glad to have been of any comfort to your poor husband, my good woman. But what made you send for me, instead of your own minister?" "Well, sir, it's 'typhus' my poor husband's got, and we dinna think it just reet for our own minister to run the risk!"—*Punch.*

Hartford, says *Puck* is literary, but not geographical. When the bronze image of H. Wells found its present resting place in Bushwell Park, this inscription was chiselled into its base: "Horace Wells, who discovered Anæsthesia." And a pretty society girl, happening to pass that way, read the inscription and wrestled with the problem therein suggested, until she reached home; and then with brow knitted with perplexity, she said to her sister: "Millie, where is Anæsthesia?" No! Hartford is not geographical.

Says the *Med. Rec.*: "There is not in France a medical school which has a professor of gynæcology, nor is there in the whole country a special hospital for the treatment of the diseases of women."

Prof. Lewis A. Stimson has been appointed to the Chair of Surgery in the University of New York, in place of Prof. J. W. Wright, resigned.

The University of Zurich has decided not to allow women attend at lectures.

Medical Council Examinations.—We beg to call attention to the advertisement in another page, of the date of the Medical Examinations.

W. E. Sprague (Trin. 1884), has lately passed the second examination in Anatomy and Physiology, R.C.P.S., London.

Books and Pamphlets.

Wood's Medical and Surgical Monographs—Consisting of original treatise and complete reproductions in English of Books and Monographs selected from the latest literature of foreign countries, with illustrations, etc. Published monthly at $10 per year. Single copies $1.00. New York: William Wood & Co. 56 & 58 Lafayette Place. Toronto: Vannevar & Co.

This series of Monographs is intended to furnish the busy practitioner with full and complete essays upon the prominent topics of the times in

the medical world. While "Abstracts" and "Progress of Medical Science" in the weekly periodicals serve to direct the attention of the profession to what is being done in the way of discoveries and in practice, these Monographs will inform him fully regarding the details of the experiments and methods which have led up to the successes attained—details essential for every one desirous of following the original thinkers in the same line of investigation or practice. Under this plan, practitioners who read only English may become acquainted with the most recent and advanced writings of prominent authors of foreign countries; a matter of great importance. The January number contains: The Pedigree of Disease, by Jonathan Hutchinson, F.R.S.; Common Diseases of the Skin, by Robert M. Simon, M.D., and Varieties and Treatment of Bronchitis, by Dr. Ferrand. The February number has: Gonorrhœal Infection in Women, by W. Jap. Sinclair, M.A., M.D.; On Giddiness, by Thomas Grainger Stewart, M.D., and Albuminuria in Bright's Disease, by Dr. Pierre Jeantin, Paris. The names of these authors speak for themselves. We can truly say that the articles are excellent. The cheapness and attractiveness of this new venture must ensure a great success to the publishers. We can heartily recommend our readers to invest in these Monographs, feeling sure that they will get the worth, and more than the worth, of their money, even in these days of comparatively cheap medical literature.

HAND-BOOK OF THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES, by Arthur Van Harlingen, M.D., Professor of Diseases of the Skin in the Philadelphia Polyclinic and College for Graduates in Medicine, etc. Second Edition, revised and enlarged; eight full-page plates and other illustrations. Philadelphia: P. Blakiston, Son & Co.; Toronto: Carveth & Co. Cloth, pp. 405. 1889.

This new edition of an already popular book is a considerable improvement upon the last. Some of the articles have been entirely re-written, and others have been added to. A few new articles, chiefly upon some of the rarer affections, have been introduced. The illustrations are a new feature, and they will, we think, aid materially in the diagnosis of skin affections. One excellent feature in the work is the explicit directions for treatment, supplemented by a large number of formulæ, rendering it a genuine aid to the general practitioner. The size is sufficient to make it fairly comprehensive without being bulky. We can say that it is a good and useful book for the general practitioner, who has not time to enter into the study of skin diseases with the same degree of minuteness that the specialist does.

THE FUNCTIONS AND DISORDERS OF THE REPRODUCTIVE ORGANS of Childhood, Youth, Adult Life and Advanced Age; considered in their physiological, social and moral relations, by William Acton, M. R. C. S., late Surgeon to the Islington Dispensary, etc., etc. Seventh Edition. Philadelphia: P. Blakiston, Son & Co., 1888; Toronto: Vannevar & Co. pp. 260, cloth.

An interesting and thoughtful book, containing much that will be of service to practitioners dealing with sexual disorders. His chapters on Impotence and Spermatorrhœa are exceedingly good. We commend the work as a good one to those interested in the questions dealt with.

TEXT BOOK OF MEDICAL JURISPRUDENCE AND TOXICOLOGY, by John J. Reese, M.D., Prof. of Medical Jurisprudence and Toxicology in the University of Pennsylvania, etc. Second edition, revised and enlarged. Philadelphia: P. Blakiston, Son & Co. Price $3.

This is a concise and readable work, setting forth in an able manner the legal points in evidence and practice required by a medical man, and also the latest tests and symptoms in toxicological cases. We can highly commend the manner in which the subject is dealt with; it is practical and clear for students and practitioners alike—a most valuable treatise.

Messrs. J. B. Lippincott Company announce to the profession the publication of a "Cyclopædia of the Diseases of Children," medical and surgical, by American, British, and Canadian authors, edited by John M. Keating, M.D., in four imperial octavo volumes, to be sold by subscription only. The first volume will be issued early in April, and the subsequent volumes at short intervals.

Births, Marriages and Deaths.

On the 18th February, at 642 Bathurst Street, Toronto, the wife of Dr. T. W. Simpson, of a son.

At 92 Merrick street, Hamilton, Feb. 16, the wife of Douglas G. Storms, M.D., of a son