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**Original Communications.**

**INFECTIVE INFLAMMATION OF THE  
VESICULÆ SEMINALES.\***

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Tubercular disease of the vesiculæ seminales is by no means infrequent; the condition is usually secondary in its development in the vesiculæ, the primary source of infection being the testicle or epididymis. This is such a well-recognized fact that in dealing with a tubercular orchitis or epididymitis, we examine the cord for thickening, and we endeavor, by rectal examination, to determine the condition of the vesiculæ seminales; our method of procedure in treatment being considerably modified if the vesiculæ be implicated in the disease.

The prostate may become involved in a tubercular process also, or the disease may be primary in the prostate, and infect the vesiculæ seminales secondarily. Is it not possible for an inflammatory process to travel in the opposite direction, affecting primarily, say the urethral tube, and involving secondarily the vesiculæ seminales? Undoubtedly the process is often reversed in this manner; thus we frequently meet with secondary involvement of the prostate and of the epididymis, the primary source of infection being the urethra, and among the common complications of gonorrhœal urethritis

are described prostatitis and epididymitis. We would be surprised if in such processes the vesiculæ seminales should be exempt from implications, and yet we are forced to one of two conclusions: either inflammation does *not* occur secondarily in the vesiculæ, or it is not recognized when it does occur. We look in vain in the standard writings on gonorrhœal complications to find any statement which warns us of the possible implication of these structures in a patient suffering from gonorrhœal urethritis.

There are close anatomical and physiological relations between the urethra, prostate, vesiculæ seminales, vas deferens, epididymis, and testicle, which may advantageously be studied in discussing the subject of this paper. The vesiculæ seminales form two sacculated bodies, each measuring about two inches long and half an inch broad, situated on the posterior aspect of the bladder, between it and the rectum. The posterior extremities of the vesiculæ are separated about three inches, the anterior extremities converge towards the base of the prostate, where their ducts join the vasa deferentia, which pass to the prostate between them. As they lie between the rectum and the bladder they are enveloped in a layer of pelvic fascia, which attaches them to the base of the bladder. The recto-vesical fold of peritoneum descends over their posterior extremities, but the greater portion of these organs is devoid of peritoneal covering. The sacculated appearance of the vesiculæ is accounted for by the fact that each is formed of

Read before the Toronto Medical Society.

a tube coiled and repeatedly doubled on itself. When this is unravelled it is found to be from four to six inches long, and from this tube there are, as a rule, several short diverticula. The duct of each seminal vesicle, about half an inch long, joins the vas deferens of its own side, just at the base of the prostate, to form the common ejaculatory duct. This common seminal duct tunnels the substance of the prostate gland and opens into the neck of the utricle, a pouch-like dilatation from the floor of the anterior portion of the prostatic urethra. Thus we have the continuity of the mucous lining of the vesicula seminalis established, on the one hand, with the urethra, through the common ejaculatory duct, and through the same channel with the vas deferens, which leads back to the epididymis. The epididymis which surmounts the testicle presents characteristics in its anatomical structure very similar to that found in the vesicula. It, too, is formed of a long convoluted tube, in which terminate the efferent ducts of the testicle; in direct continuation of the convoluted tube of the epididymis being the vas deferens, the excretory duct of the testicle, which is nearly two feet in length.

We have thus a long continuous stretch of mucous membrane lining the urethra, and the ducts which I have described in relation to the male generative organs. The arteries of the vesiculæ are derived from the inferior vesical branches of the internal iliac; the veins pass into the prostatico-vesical plexus; the lymphatics are very numerous, and end in the middle hypogastric glands. The nerves belong to the sympathetic system and come from the hypogastric plexus.

Functionally, we have to consider the system of tubes as composed of two factors. First, that portion of it which belongs solely to the genital apparatus, and, secondly, that portion of it which is common to the urinary and genital systems. The urethra is frequently being flushed out by the passage of urine; on the other hand, the tubular system which belongs purely to the genital apparatus is not subjected to the same flushing process. The urethra may be the seat of an acute inflammation, and yet the passage of urine goes on, unless, indeed, there be retention; on the other hand, the genital ducts when acutely inflamed are not subjected to the same process.

In gonorrhœal epididymitis, it is probable that the inflammation travels from the urethra along the ejaculatory ducts and vas deferens. When we consider the path it takes, the long course from the prostatic urethra to the epididymis, we must necessarily expect that other structures nearer at hand and in more intimate relation to the prostatic urethra would take part in the inflammatory process. We would therefore expect to find the prostate or the vesiculæ seminales frequently implicated, and, in fact, more frequently the seat of secondary infection than the epididymis. As a matter of fact, the frequent occurrence of prostatitis is said to be perhaps the commonest complication of gonorrhœa; the ducts of the prostate gland open into the prostatic sinus in the floor of the prostatic urethra, and no doubt along these ducts the inflammation may travel. It would, indeed, be curious if the ducts proper to the prostate should be selected by the inflammatory process and the ejaculatory ducts escape.

It is worthy of note that the symptoms of acute inflammation of the prostate would present characteristics very similar to those presented by inflammation of the vesiculæ seminales: this is accounted for by the intimate anatomical relationship existing between the structures. Their position and their relation to the neck and base of the bladder are almost identical; the effect produced and the referred pain caused by the contracting bladder would be the same in the case of inflammation of either structure. To a certain extent this is accounted for by the common source of the vascular supply and the similarity of the nerve and lymphatic connections of these structures. It would therefore be difficult to diagnose, between the two conditions, and it is probably on this account that inflammation of the vesiculæ seminales is seldom, if ever, recognized. Further, we may look for conditions in which both prostate and the vesiculæ seminales are affected at the same time; this is possible, and probably occurs. Under such circumstances the physical signs would be those present in ordinary prostatitis.

Inflammation of these structures at the neck of the bladder is often very persistent, the pain is intense, and is greatly exaggerated after the

act of micturition. When this condition is unduly persistent, and all ordinary remedies fail to give relief, the patient continuing to suffer for weeks, or even months, we may suspect that the trouble is located in the vesiculæ seminales and not in the prostate. We must not come to this conclusion on these grounds alone, but an examination per rectum may aid us, and we may be able to detect the position of an inflamed vesicula seminalis, which we will find indurated and very tender, occupying a position extending beyond the base of the prostate. The inflammatory process in the vesiculæ seminales follows a similar course to that occurring in the epididymis, an organ of a like anatomical structure, namely, a convoluted tube. We are familiar with the character of the inflammatory process in the epididymis. At first, very acute with intense pain, and probably high fever; after the acute stage has passed off, a subacute stage supervenes, in which there is still a considerable amount of tenderness and the organ remains indurated; the induration and pain may persist for some months; supuration may occur, and is by no means infrequent. We find the statement made that inflammation of the prostate may lead to supuration and the formation of an abscess. It is quite possible, however, that many of the abscesses which are supposed to originate in the prostate are really in the vesiculæ seminales.

Mr. Jordan Lloyd recently read a paper on what he termed "Spermato-cystitis,"\* dealing with the subject of inflammation of the vesiculæ seminales. In that paper Mr. Lloyd makes the following statement: "So little attention has been paid to inflammatory diseases of the seminale vesicles, that the subject is dismissed in a few words, even in special monographs upon venereal or genito-urinary disorders; but since my attention was first directed to the subject I have met many cases, and have satisfied myself that these maladies are by no means rare. They are, indeed, amongst the most common complications of gonorrhœa. They are usually overlooked, not because they do not give rise to definite signs and symptoms, but because these symptoms are misinterpreted and are wrongly attributed to diseases of different organs altogether." The history of the follow-

ing case, recently under observation, suggested the implication of the seminale vesicles in a gonorrhœal inflammation. H.D., æt. 24, contracted a gonorrhœa: the pain and urgency from which he had suffered in the early stages of the attack had subsided, and the discharge had almost ceased, when at the beginning of the third week he was seized with severe pains, deeply seated in the perineum. Hot fomentations were applied and antipyrin administered. Despite this treatment the pain increased so greatly in a few hours that it was necessary to administer morphia hypodermically for his relief. A mixture containing chloral and bromide was prescribed, and during the next few days the pain diminished somewhat, but then recurred with increased severity, so that morphia was again necessary. During this time he had increased frequency of micturition and urgency. In order to check the irritability of the bladder, bicarbonate of potash and tincture of hyoscyamus were administered, and the bowels were kept regular by giving sulphate of magnesia. Three weeks after the onset of these symptoms, the pain at that time being much less acute, an examination was made per rectum. This revealed the presence of a swelling on the posterior aspect of the bladder. It was more marked to the right of the middle line than on the left, and its posterior margin was not determined. The examination caused him much pain, and there was excessive tenderness on pressure over the swelling. It was thought probable that the inflammation was situated in the seminale vesicles, more marked on the right side than on the left. During this time the urine was examined frequently. It was noticeable that the urine first voided was clear and of normal appearance. At the end of the act of micturition, discharge of mucopurulent material took place, accompanied by blood; the amount of blood lost from time to time varied but was usually small. The urine was of spec. grav. 1006 and alkaline reaction, albumen 1/8th contained pus cells; there were no casts and no epithelial cells. During the second and third weeks of the attack (fourth and fifth weeks of the gonorrhœa) the most distressing symptom was the urgency of micturition. The pain was no longer constant, but he suffered acutely after voiding urine, the pain lasting a variable

time, from ten minutes to half an hour. The usual remedies were tried: alkalies with *uva ursi* and *triticum repens* were administered, giving these in large doses without any appreciable effect. A suppository, containing extract of belladonna gr. i, was then ordered every sixth hour; this at once began to take effect, the frequency became less, the pain diminished, and the hemorrhage soon stopped. During his illness he had been kept resting in bed, living on a milk diet, and had been taking freely of diluent drinks, chiefly barley water. His general health had suffered much, and a tonic was now prescribed, containing iron and strychnine; all other treatment was stopped, save the belladonna suppositories, which were still necessary. Improvement was very slow, and three months after the onset of the attack the following condition was noted: he had gained strength considerably, and was able to walk about without pain: there was still a certain degree of frequency, rarely did he go more than two hours without passing water; then, again, he usually had an attack of pretty severe pain once in twenty-four hours, the pain lasting an hour or more; he still found it necessary to take a belladonna suppository occasionally; if he neglected to do this, the frequency increased and the pain became aggravated. It was found later that the pain could be held in check by anticipating its occurrence and administering gr. 15 of quinine before its onset. Having sufficiently recovered from the attack at this stage, he was advised to go to the seaside for a few months, hoping that he would benefit by the change of climate.

The history recorded above is that of a case of very common occurrence. The signs and symptoms are usually, and we are forced to believe wrongfully, attributed to an inflamed prostate. Suppose we grant that the prostate may be inflamed in a gonorrhœal urethritis, would it not be remarkable if the vesicles should invariably escape?

The difficulty in diagnosis is conceded. If there be difficulty in distinguishing an epididymitis from an orchitis, there will be still greater difficulty in determining between an induration of the seminal vesicles and a like affection of the prostate. In the case of the inflammatory tumor in the scrotum, it is sometimes well-nigh impossible, by palpation, to make certain

whether we are dealing with an inflamed testicle or an inflamed epididymis; of course this remark applies only to certain stages in the process. When, on the other hand, the tumor is situated at the neck of the bladder, it must be still more difficult to differentiate between the two possible conditions in that locality, the vesiculæ seminales and the prostate lying in such intimate relation with one another, and, when either organ is the seat of an inflammatory swelling, the post-vesical tumor would occupy very much the same locality; then, again, we cannot reach these organs by direct palpation; we can only examine them through the anterior rectal wall. The symptoms and signs of inflammation of the vesicles are similar to those usually ascribed to the acutely inflamed prostate; the condition usually develops in the third or fourth week of the gonorrhœal attack: pain deep in the pelvis and perineum, and towards the end of the penis; frequency of micturition and urgency, with a severe exacerbation of the pain on completion of the act of micturition: the urine first passed is of normal appearance, but towards the end of the act of micturition there is a muco-purulent discharge, with blood occasionally. An examination per rectum yields, however, the most characteristic sign, and here, again, I quote from Mr. Lloyd, who has studied a large number of cases. He says "the swelling will be found to occupy the whole of the base of the bladder from side to side, and to extend beyond the reach of the finger." He states, as his opinion, that he cannot conceive it possible that the prostate, shut up as it is in its own fibrous capsule, can swell up to this size in the course of a few hours. He asserts his belief that inflammation of the prostate is a disease of comparative rarity; on the other hand, he considers inflammation of the vesiculæ seminales of common occurrence.

It is the peri-vesicular connective tissue which is the chief seat of the inflammatory process, resembling in this particular a similar condition in the epididymis. The usual termination is that of resolution, but suppuration may supervene. The abscess formed may open in the perineum, or into the rectum, bladder, or urethra, and it is stated that Douglas' pouch may be opened up and the pus discharged into the peritoneal cavity.

The tendency of infective inflammation to spread along mucous canals is constantly observed: it may travel from the urethra to the bladder, ureters, and the kidneys, as well as along the genital ducts; then, in the female, the dependence of many cases of salpingitis on gonorrhoeal infection is well established.

The treatment of the condition may be considered from two points of view: (1) Preventive; (2) palliative and curative. The administration of diluent drinks and diuretics during the acute stage of gonorrhoea does much to prevent passage of the inflammation backwards along the urethral canal. A flushing-out process is thus carried on, and the poison is by this means, to a certain extent, got rid of. On the other hand, urethral injections during the early stage of a gonorrhoea are to be condemned; they may, it is true, do good, but a great danger exists of carrying the virus backward, setting up infective inflammation near the neck of the bladder. When inflammation of the vesiculae seminales has been established, then our flushing-out process will have little effect upon it: nevertheless we must not even then employ urethral injections, for fear of carrying the inflammation still further back in the prostatic urethra to the bladder, with the danger of setting up a gonorrhoeal cystitis. The passage of instruments must be avoided if possible, as the same danger is encountered there. We can do much to allay suffering by ordering a hot hip bath. Occasionally the injection of cold water into the rectum is grateful to the patient. The better way of relieving pain and diminishing frequency, however, is by administering belladonna in the form of suppositories. The bowels must be kept active by saline cathartics. The patient should be kept on a milk diet and stimulants prohibited. These are the chief indications in treatment. When the acute stage has subsided, tonics of iron, strychnine, or quinine are serviceable. Quinine seems to be of use also in diminishing frequency, although its specific action here is not generally recognized. If an abscess forms it must be opened early because of the danger, if tension be not relieved, of the pus burrowing in dangerous localities.

The object in writing this paper has been simply to call attention to the fact that these organs may be the seat of a serious infective in-

flammation, and, if possible, to excite some interest in the subject in order that keener investigation may be made when dealing with inflammation in this neighborhood.

## CLINICAL REMARKS ON CASES OF ANÆMIA,

In Toronto General Hospital, under the care of

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*Case 1.—Chlorosis.* Maud M., seamstress, æt. 23. Was well until two years ago, when she took cold and was ill for two months, during which her feet swelled somewhat. She recovered, but never regained her usual health. Last winter she took cold again, with severe cough, but without expectoration. The swelling, especially of the legs, increased considerably. There was also considerable palpitation, with pallor, which now began to assume a yellowish tinge. She had recurrent attacks of illness without the history of any special ailment. She entered the hospital last October, being still able to go about, and having a fair appetite. She is now (January, 1892) unable to leave her bed. You see she is very pale, with a marked greenish-yellow tinge; conjunctiva pearly; lips pallid; tongue pale, flabby, and teeth indented. There is abundant subcutaneous fat, and she would look fat even were there not so much œdema, which has only lately, she says, become marked. Now there is considerable ascites and some hydrothorax. There has lately been a very troublesome diarrhoea, with offensive stools. Menstruation was regular until two years ago, when it became irregular and scanty. For some months back menses have been absent. The lungs are healthy. The heart shows a well-marked mitral regurgitation, and to this, with the great degree of anæmia, is due the dropsy. The blood contains only 1,000,000 corpuscles per centimetre: they have little tendency to form rouleaux, are regular in shape and normal in size, but very pale, so that the number of corpuscles is in excess even of the amount of hæmoglobin. The urine is rather pale; sp. gr. normal. The liver and spleen are large, doubtless on account of the defective circulation due to the disease of the mitral valve.

This woman presents all the typical characters of chlorosis: Absence of emaciation, the green-

ish-yellow pallor, the amenorrhœa and hæmic murmur over the base of the heart and root of the neck. Usually in these cases there is constipation, to which the anæmia has been attributed by some. There has been constipation here, and the diarrhœa at present is probably due to decomposition of the intestinal contents, resulting in irritation and increased peristalsis. Bismuth and beta-naphthol to disinfect the bowel, with small doses of opium to allay irritability, will probably control it. If constipation persisted, laxatives persistently used, to maintain free evacuation, would be necessary. In many cases laxatives, with plenty of food rich in iron, as meat and eggs, are sufficient to effect a cure. The explanation of this is probably to be found in the fact that the saline, by keeping the bowel free from fecal matter, not only prevents damage to the blood by poisons that may be absorbed from too long retained feces, but may succeed also in keeping the bowel clear of poisons that combine with, and thus render useless, the iron compounds of the food. Iron in all forms, given as medicine in anæmia, is of use, partly at least, in combining with those poisons, mostly sulphides, in the intestinal tract, and thus saving the iron compounds of the food from being affected by them. This would explain the greater use of large doses of iron, which often succeed when small doses fail. For these reasons this patient is getting large doses of *tr. fr. perchloridi*. This will explain, also, the reason that so many of the more pleasant compounds containing iron fail in anæmia; they are of use chiefly on account of the other ingredients, as quinine, strychnine, etc., which enter into these compounds. They do not contain enough iron to neutralize these intestinal poisons, and therefore usually fail where *tr. fer. mur.* succeeds. The prognosis, usually favorable in chlorosis, is unfavorable here, on account of its imperfect circulation and consequent dropsy. Chlorosis seldom, if ever, proves directly fatal, but it renders its subjects more liable to, and less able to resist, other diseases, especially gastric ulcer and tuberculosis.

*Case 2.*—Ellen F., servant, æt. 34. Another case of chlorosis, lacking the typical appearance. She illustrates another phase of this disease. She was well, menses regular, up till 20 years of age. For next 7 years was troubled

much with indigestion, and during last 7 years she has become ill about November of each year, illness lasting a variable time. Complains of weakness, breathlessness, general headache, faint feelings, etc. Since the age of 20, menses have been irregular. Now there is only a stifled colorless monthly discharge, lasting one day.

Her appearance, you notice, contrasts strongly with the last case, and she lacks the fat appearance, though not emaciated. She is pallid, with slight yellow tinge and dark pigmented area below the eyes, indications of bad digestion. There is no œdema; appetite fair; bowels free before coming to the hospital, constipated since. The heart, lungs, and other organs appear normal. Urine is very pale at times, copious; sp. gr. 1012, slightly acid. These characters are especially marked when she is nervous and hysterical, as she is frequently. There are hæmic murmurs at base of neck. The blood contains 2,400,000 red corpuscles per cmm., about 50 per cent. of the normal number. The corpuscles are normal.

There is little here to distinguish it from an ordinary case of simple anæmia from dyspepsia and mal-assimilation, and it might be classed as one. There is not a distinct division between the two conditions. In typical chlorosis, besides the characteristic appearance of the patient, the blood presents a greater reduction of its hæmoglobin than of its corpuscles; e.g., there may be 75 per cent. of the normal number of corpuscles present and only 50 per cent. of hæmoglobin.

Chlorotics may be conveniently divided into two classes: First, those who acquire the disease after maturity, as in these two cases; these are the most frequent, and are usually quite successfully treated, though liable to relapses. In the second class, the disease begins with puberty. In these, according to Virchow, there is immaturity of uterus and ovaries and of the heart and large vessels. He found the heart small and the aorta small and its walls thin. For example, he found, in fully developed women, specimens in which the aorta would receive only the little finger, while normal aorta should admit the thumb. Others, again, deny that such immaturity ever results from chlorosis simply, or rather occurs in chlorosis apart from other causes. Fagge says that in those cases

with small aorta there has been present stenosis of the mitral or aortic orifice: that such was the case in some, at least, of Virchow's own cases. In cases with such stenosis occurring early in life, the aorta is not rarely found narrow throughout its whole length.

The division of chlorotics into these two classes is useful, however, from a clinical point of view, as those in whom the symptoms show themselves later in life respond much more readily to treatment, and in them the prognosis is better, as to permanent cure, than in those in whom the disease manifests itself at or before puberty.

*Case 3.—Pernicious anæmia.* By way of contrast the following case, at present under treatment, offers a striking example: Mrs. S., æt. 50, a seamstress. Had always been a hard-working, vigorous woman until early last summer, when she began to lose color and strength. Her digestion became poor, with occasional attacks of vomiting and frequent diarrhœa, the stools being usually rather offensive. Her condition, with occasional periods of improvement, gradually grew worse throughout the summer and autumn, with development of a decidedly greenish-yellow color, similar to Case 1. She also became more than usually stout. Later, considerable œdema occurred. I saw her first about Christmas, when she was scarcely able to leave her bed. Her lips and tongue were very pale; conjunctiva pearly; finger nails without color; temperature, from 98° to 100°; pulse, weak. She had attacks of vomiting, with slight fever, every few days, and diarrhœa was troublesome. No evidence of disease could be found in any organ. This is a sample of the urine passed during one of those paroxysms. You observe it is a very dark, port wine color. It becomes much paler, though still dark, on the days on which she feels better, at which time there is no vomiting and often no diarrhœa. With a return of the slight feverishness with vomiting, the urine again becomes dark. The urine contains no albumin, but a good deal of granular pigment; sp. gr. 1022, low for such dark urine; it is decidedly acid. Sp. gr. does not fall when it becomes paler.

The blood appears dark; on the slide the corpuscles tend to form clumps, but not rouleaux. There is considerable irregularity in

their shape, and the great majority of them measure from 10 to 12 *m.*: the normal, you know, is about 7.5 *m.* There are some microcytes but not many, and very few very large corpuscles. There is a good deal of granular debris in the blood. The number of corpuscles per cmm. was about 1,000,000, and the amount of hæmoglobin was certainly in greater proportion. The number of red corpuscles, you see, was the same as in Case 1, but the blood was much darker.

A diagnosis of pernicious anæmia was made on the following facts: The gradual onset of the anæmia without apparent cause except disturbed function of stomach and bowels; absence of emaciation: the lemon-yellow tint: the slight fever, occurring paroxysmally; the irregular vomiting and diarrhœa; the urine, dark at all times, but especially so during the paroxysms: its relatively low sp. gr. and abundant pigment deposit; the condition of the blood. Most of these symptoms might occur separately in many diseases, but collectively in probably no disease but pernicious anæmia. The condition of the urine is especially significant: Acid, low sp. gr., with high color. The sp. gr. in this case is higher than in any case that I have seen. It has always been below 1020 in other cases. This may be due to the very weak circulation in this woman, which led also to the anasæra. The condition of the blood is probably pathognomonic. In no other disease is the diameter of the great mass of red corpuscles increased to 10 to 12 *m.*: some very large corpuscles may be present in any grave anæmia, but not this fairly uniform moderate enlargement. The disease, as you already know, is characterized by great destruction of blood corpuscles in the portal vein, more or less paroxysmal, probably by some poison of the nature of ptomaine absorbed from the intestinal tract. The excretion of the pigment resulting from this rapid destruction accounts for the dark urine, the sp. gr. of which is low on account of defective metabolism in the tissues generally. On account of this great destruction of corpuscles, the bone medulla is stimulated to its utmost in the attempt to furnish new corpuscles to take the place of those destroyed. Consequently immature large corpuscles are thrown off; and as no other disease is characterized by such rapid destruction of

corpuscles, no other disease would, consequently, be characterized by the presence of such general enlargement of red blood corpuscles.

The first and third of these cases have certain points of great similarity. For example, absence of emaciation, as occurs in primary anæmia; generally; the pallor with the lemon-yellow color; the weakness; and the great reduction in red corpuscles. The points of difference are: The character of the urine; the relative proportion between corpuscles and hæmoglobin; the normal corpuscle of the chlorotic case as contrasted with the typically altered corpuscle of the case of pernicious anæmia; the anæmia of the chlorotic case resulting from deficient production of corpuscles without increase in destruction of them; in the other, the anæmia resulting from excessive hæmatisis in the portal system, which hyperactivity of the blood-forming medulla makes vain efforts to repair; lastly, the prognosis differs widely, generally favorable in the one, while the other terminates too often fatally, even when most judiciously treated.

The treatment of pernicious anæmia may be summed in one word—*arsenic*. Of course, good nourishment must be given, and intestinal antiseptics, as beta naphthol, may be of benefit, although I cannot say that I have had any good from their use. To this patient liquor arsenicalis was given every three hours, after nourishment, *mij* at first, and gradually increased to *mv*, so that she has been taking from 30 to 35 minims per day. This was continued for six weeks without any sign of disturbance of stomach, by which time the blood contained over 2,500,000 corpuscles per *cmm.*, of almost normal appearance, the œdema and lemon color had disappeared, good color had returned to lips, tongue, and nails, and the woman was able to walk out. Appetite returned, and she was able to take ordinary diet with relish. The urine became normal. Then, lest the arsenic should cause peripheral neuritis, it was stopped and dilute muriatic acid and *nux vomica* are now being taken. If necessary, arsenic will be given again, but I have seen one case continue to improve uninterruptedly without its further administration. Arsenic probably acts on the corpuscles, enabling them to resist the poison, thus preventing their destruction.

The greatest patience and perseverance is needed in treating these cases until they begin to improve well. They find it difficult to take both medicine and food; vomiting is usually fairly frequent, and diarrhœa much more so. They are extremely weak and low spirited, so that much tact and hopefulness is needed in their management and nursing. If the case is far advanced and the stomach does not retain the arsenic, it would be well to resort to hypodermic injection for a few days, and nourishment by the bowel should be tried.

These cases can scarcely be diagnosed with certainty before the red corpuscles are reduced below 50 per cent. of the normal. The natural pink color of the finger nails will be preserved until this reduction is reached at least, so that if the nails are pallid we may be certain that at least 50 per cent. of the corpuscles are lost and probably more.

In giving a prognosis in pernicious anæmia, it must be borne in mind that there is great liability to relapses. The histories of cases in the past have shown that the majority have ultimately died notwithstanding the most judicious treatment perseveringly carried out; but more recent results have I think, been more favorable as arsenic has been given more perseveringly and more freely.

It will be found of practical use to remember that in the treatment of anæmias, as a rule, arsenic should be given in all cases in which the amount of hæmoglobin is in excess of the red corpuscles, and iron is indicated when the hæmoglobin is in equal or less proportion than the red corpuscles. In Case 1 arsenic was, I understand, given freely for over a month without any improvement, while the condition of the blood has improved somewhat with the free administration of iron: yet, of course, we do not expect much improvement in view of the disease of the heart and the resultant anasæra. Likewise in Case 3, iron had been given freely for a long time without benefit; of the results with arsenic I have already told you. Arsenic does equally well in some cases of splenic anæmia.

SIR JAMES PAGER'S SON is an English clergyman, and has recently been appointed Dean of Christ Church, Oxford.

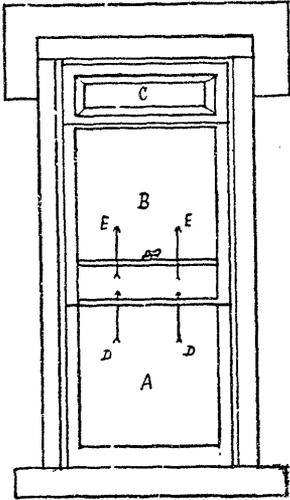
## A NEW VENTILATING APPLIANCE.

BY A. M. ROSEBRUGH, M.D.,

Late Surgeon to the Toronto Eye and Ear Infirmary.

I desire to call the attention of the profession to a new appliance for window ventilation. The object is twofold: Firstly, to afford diffusion of fresh air without perceptible draughts; and, secondly, to make the ventilating appliances in a form that will add to, rather than detract from, the appearance of the windows and the building, and thus to make them self-recommendatory.

The ventilating appliance consists of a short supplemental sash—preferably ornamental—placed at the upper part of and outside of the window, and close against the top part of the



OUTSIDE VIEW OF WINDOW VENTILATOR.

A, lower inside sash; B, upper outside sash; C, supplemental sash; D E, D E, arrows, representing ventilating space between sash A and sash B.

upper sash. This supplemental sash placed in this position affords simple means for changing a direct draught into an indirect draught when the top sash is lowered for ventilating purposes. The extra sash forms a block to the passage of a direct draught over the top of the upper window sash, while a syphon-like space is afforded for the passage of an indirect draught by the overlapping of the upper and lower sash. It is not new to ventilate buildings by utilizing the space caused by the overlapping of the two window sashes, but heretofore this was done by the cumbrous method of placing a piece of planking below the lower sash. The cumber-someness of this method has prevented its general adoption.

By placing the ventilating appliances at the top instead of at the bottom of the windows, by making them a fixture requiring no attention, and by substituting ornamental sashes for unsightly loose pieces of planking, the new ventilating appliances become self-recommendatory. They render window ventilation simple and easy, and I see no reason why they should not make it popular as well.

By admitting the fresh air between the overlapping sashes three important points are gained, viz.: Firstly, by treating several or all the windows in this manner, the number of inlets and outlets prevent the concentration of the draught at any one point in the room, the fresh air is diffused, and perceptible draughts are avoided. Secondly, the inlets are at the right height to prevent unpleasant draughts on the person. W. P. Buchan, in his late work on ventilation, states that five feet six inches from the floor is the very best point for the admission of fresh air into a living room or a sleeping chamber. Thirdly, by admitting the fresh air through the syphon-like space between the overlapping sashes the fresh air is directed upward towards the ceiling. This can be very easily verified by a simple experiment; as, for instance, by using lycopodium seeds or the phosphorous acid given off at the first striking of a match before heat is evolved from the burning of the sulphur.

With a view of testing the efficiency of the ventilation, the following tests were made at my consulting rooms, where I have four windows equipped with the ventilating appliances, viz., two windows facing the west and two windows facing the east, and the two rooms *en suite*. On December 2nd, with the air meter, I found the air entering between the overlapping sashes at the rate of 240 feet a minute, and on December 12th at the rate of 440 feet a minute. On both occasions the wind was from the west. This gave 3000 sq. ft. per hour on the 2nd, and about 5500 sq. ft. on the 12th, as the two windows on the west gave a total ventilating space of 30 inches.

Where windows on opposite sides of a room or building are equipped with these ventilating appliances, both an inlet for fresh air and an outlet for foul air is afforded—"cross ventilation"—the direction of the current varying with

the direction of the wind. This method of admitting fresh air may be combined with any of the usual systems of removing foul air, such as by the use of fans, by cowls, or by artificially heated flues.

This system of ventilation, it seems to me, is particularly well adapted to bedrooms and sick chambers, where it is desirable to have a constant supply of fresh air with freedom from unpleasant or dangerous draughts. It may also be made to supplement any other system of ventilation.

I have suggested to some parties the propriety of taking up the manufacture and putting in of these ventilating appliances as a business, but so far without success. If the co-operation of the medical profession could be assured, there would be no difficulty. Would it be too much to bespeak such co-operation?

With regard to the question of cost, I find that plain ventilators, suitable for bedrooms and rear premises, can be put up for about 50 cents each, while ornamental sashes would cost from \$1.25 up, according to width of window and according to the style of the ornamental glass.

## Selections.

### OXYGEN GAS IN ACUTE RESPIRATORY AFFECTIONS.

BY E. MARKHAM SKERRITT, M.D. LOND., F.R.C.P.,  
Senior Physician to the Bristol General Hospital: Lecturer  
on Medicine at the Bristol Medical School.

My experience of the effects of oxygen in the following case has convinced me that Drs. Lauder Brunton and Prickett have done good service in calling attention afresh to the therapeutic use of this gas. As in the instance which they describe, a fatal issue was not averted, but the effect was such as to indicate the probable value of oxygen under more favorable conditions.

Last October, Dr. Parsons, of Cotham, asked me to see in consultation with him a gentleman, æt. 66, who for many years had suffered from bronchitis and emphysema. At that time there were no urgent symptoms, but the patient had advanced pulmonary emphysema, with secondary dilatation of the heart, and in consequence was always the subject of more or less dyspnea.

On January 24th I saw him again in consulta-

tion with Dr. Parsons and Dr. Newman, of Bristol. His temperature was then 102.8°, and he was wandering; dyspnea and cyanosis were very marked, and extensive bronchitis and broncho-pneumonia existed. Next day there was no improvement, and we therefore decided to administer oxygen. At 7 p.m., when the inhalations of the gas were begun, the pulse was rapidly failing, the surface was very dusky, and the patient was fast approaching his end. The immediate effect of the oxygen was most striking; the pulse improved wonderfully in tone, and the cyanosis completely disappeared; as the hands were watched the blue color under the nails could be seen fading away and giving place to a healthy pink. The change was so marked that it was evident to all present. When the inhalation had ceased for a few minutes, however, the pulse again began to fail and the cyanosis to return—to be again removed by the fresh administration of the gas. This sequence recurred again and again, until at length the oxygen was given more or less continuously. Strychnine was also injected subcutaneously. In the early hours of the following morning, however, the effect began to be less marked, and the patient gradually sank and died about 9 a.m.

The influence of the oxygen in this case in removing cyanosis was extraordinary and altogether beyond doubt. The conditions under which it was given, however, were most unfavorable. The occurrence of extensive bronchitis and broncho-pneumonia upon long-standing and advanced emphysema, with weakened heart, made the outlook practically hopeless; but we were convinced that at all events life was prolonged by some hours, and Dr. MacCarthy, of Worcester, who was present during the night and kindly helped with the inhalations, concurred in this view. In my article in Cassell's *Year Book of Treatment for 1892* (p. 40, sec. 2) reference is made to a case of pneumonia reported by Dr. Blodgett, in the *Boston Medical and Surgical Journal*, in which the influence of oxygen is said to have been "almost as pronounced and evident as is that of ligature in hemorrhage," and in the face of our experience this can hardly be considered an exaggeration. I have never seen such an extraordinary effect upon cyanosis produced by any other means, and, for the future, in any case of acute respi-

ratory affection threatening to prove fatal I shall not consider that everything practicable has been done unless a fair trial has been given to oxygen.

The gas was obtained in cylinders from Brin's Oxygen Company, 34 Victoria St., Westminster, and by the courtesy of the local agent, Mr. C. H. James, of 30 Broad St., Bristol, it was received in Bristol within five hours of the despatch of the order. The company supply a simple apparatus, consisting of a rubber bag connected with the cylinder, and also with a tube, to which a mouthpiece can be attached. The bag can be hung up above the level of the patient, so that the gas which enters it from the cylinder escapes slowly through the delivery tube by its own weight and the collapse of the bag.

When the inhalation was begun the patient was breathing through the mouth; but directly the end of the tube was put into his mouth he grasped it with his lips and breathed through the nose alone. The tube was therefore fitted into an ordinary naso-oral celluloid inhaler, which answered well. No unpleasant effects were produced. It is better to use the bag rather than to give the gas direct from the cylinder, as it is contained in the latter under such pressure that it is difficult to regulate its escape.

Now that pneumonia and bronchitis are so prevalent and so fatal, the recognition of the value of oxygen in staving off asphyxia and stimulating the heart may lead to the saving of life in otherwise hopeless cases.—*British Medical Journal*.

**EPISTAXIS—AN EASY AND EFFECTUAL METHOD OF PLUGGING.**—Undoubtedly, plugging the nares by aid of Bellocq's cannula is an excellent method; but occasionally, especially in country practice, a Bellocq's cannula is not at hand, and some method easy, effectual, and effected by materials always within reach, must be resorted to. Such a method I have found in the following. A piece of old, soft, thin cotton or silk, or oiled silk, about six inches square (a piece of an old handkerchief will answer) is taken, and, by means of a probe, metal thermometer case, or penholder, or anything handy, is pushed centre first, umbrella fashion, into the nostril, the direction of pressure when the patient is sitting erect being backwards and slightly downwards. It is pushed on in this

fashion until it is felt that the point of the "umbrella" is well into the cavity of the naso-pharynx. The thermometer case or probe, or whatever has been employed, is now pushed on in an upward direction and then towards the sides, so as to pull more of the "umbrella" into the naso-pharynx. The thermometer case is now withdrawn. We have now a sac lying in the nares, its closed end protruding well into the pharynx behind, and its open end protruding at the anterior opening of the nares. If it be thought necessary, and is convenient, the inside of the sac may be brushed with some household astringent, such as alum solution, turpentine, etc. A considerable quantity of cotton wool is now, by means of the thermometer case, pushed well back to the bottom of the sac. Then, the thermometer case being held firmly against the packed wool, the mouth of the sac is pulled upon, and thus its bottom with the wool packed in it is pulled forward, and forms a firm, hard plug wedged into the posterior nares. We may now pack the sac full of cotton wool, dry or soaked in some astringent solution. The mouth of the sac may now be closed by tying it just outside the nostril with a piece of strong thread; it is then trimmed by scissors and the ends of the thread secured outside. The foregoing method is easier than any I know when both nostrils have to be plugged. It might be suggested to oil the cotton or silk in order to render its introduction easy and to prevent it adhering to the mucous membrane, and to render it easy of removal; but I have never found any difficulty without the oil, as the blood renders the material wet and easy of introduction, while the oil does not facilitate removal, and may modify the effect of the astringents that may be used. The plug may remain *in situ* as long as any other nose plug. In removing the plug, open the mouth of the sac, and with small dressing forceps remove the cotton wool bit by bit; if there is bleeding, simply syringe the sac with weak carbolic lotion, or Condy's fluid, and repack with clean cotton wool, or wool impregnated with some antiseptic. If there is no bleeding when the wool is picked out, gently pull out the sac; or if it be adhering to the mucous membrane, syringe in a little warm water, and it may then easily be removed. This method has many advantages. (a) It is easy, quickly

accomplished, and effectual, and the materials are to be found in every house, and, indeed, about everybody's person (I have plugged in this manner, simply using a handkerchief, one part of which was used for the sac, and the other, torn into narrow strips, in place of the cotton wool); (*b*) no damage is done to the floor of the nose or back of the soft palate by strings, etc.; (*c*) no disagreeable hawking, coughing, or vomiting takes place while the plug is introduced; (*d*) there are no disagreeable strings left hanging down the throat, causing coughing or sickness while the plug is in; (*e*) the plug can be removed gently without any force, so that no damage is done to the mucous membrane and no return of hemorrhage caused.—*A. A. Philip, M.B., C.M.—Lancet.*

**INFLUENZA IN CHILDREN.**—There seems to be a prevailing impression that infants and young children are not attacked by influenza. That this idea is wrong, however, many practitioners can testify; it is naturally difficult to diagnose in such patients, but the fact that they sicken when their parents or nurses are affected with the disease is strong presumptive evidence that they also are attacked. Dr. David Fuchs, of Budapest, is of this opinion, and publishes a short article on the subject in the *Allgemeine Wiener Medicinische Zeitung* of Jan. 19th of this year. He states that he has met with many cases of influenza in young children, but that the symptoms and course of the disease differ in some particulars from those occurring in the adult. As a rule, the attack is lighter. It commences with fever, and the onset is sudden. One day the child may be perfectly healthy, whilst on the next is severely ill without any prodromal symptoms having developed. The temperature does not generally rise above 103° F., though it may occasionally be as high as 104°. After lasting twenty-four hours, the fever commences to subside. With many children cerebral symptoms predominate. Dr. Fuchs records one case in which a child, aged eighteen months, was, without any warning, seized with severe laryngeal symptoms, followed by convulsions, whilst the temperature rose rapidly to 104°. Vomiting is a very common symptom. Next in frequency come affections of the mucous membranes. The conjunctivæ are injected,

and there is catarrh of the throat and nasal passages. In this stage the general appearance is very similar to the early stages of measles. The tongue is coated, and the child gradually subsides into an apathetic state. Older children complain of severe headache. The bowels are usually confined. There is not unfrequently a peculiar rash; it appears on the trunk and lower limbs, and takes the form of small papules not unlike the exanthem of varicella. Its extent varies greatly, and the number of spots may be very few or the reverse. In one child eighteen months old a few small pemphigus vesicles appeared on the backs of the legs, which were at first filled with a clear fluid, but afterwards dried up. Bronchial catarrh, usually slight, frequently follows. After these symptoms have lasted a few days, the temperature becomes normal, and the inflammation of the conjunctivæ and nasal mucous membranes disappears. The other catarrhal phenomena last longer, and the troublesome cough is difficult to get rid of. The exhaustion is considerable, and even after an illness of only three days a strong child will be very much pulled down. The prognosis is in nearly all cases favorable. Although weakly children suffer more than those who are stronger, serious complications rarely set in, and pneumonia is but rarely met with. The treatment is symptomatic, and Dr. Fuchs advises that no antipyretic drugs should be given, as they only tend to depress the patient. He recommends isolation.

**THE CENTRE FOR HEARING.**—A case of no little interest and importance in this connection is recorded by Dr. C. K. Mills in the current number of *Brain*. The patient, a woman of forty-six, was admitted to the hospital in August, 1891. Her history made it probable that she had suffered from specific disease. She was right-handed. Fifteen years before she had a "stroke," which left her word-deaf, but not paralyzed. She could hear musical and other sounds, but she could not understand words; yet she could apparently read and understand a paper, although in an attempt at reading aloud she made a jumble of the words, and a similar imperfection was present during ordinary attempts at speaking. She was able to write, but wrote wrong words. Six years later she

had another stroke, affecting the left side of the body, and leaving her partially paralyzed on that side; then her hearing was much impaired, so that there was not only word-deafness, but deafness also for ordinary sounds. Her condition, when examined by Dr. Mills, was one of almost complete helplessness. It was impossible to make her understand what was said to her, and after repeated tests the conclusion was come to that she was totally deaf. She died of exhaustion, and at the necropsy the left superior temporal convolution was found to be much atrophied, except anteriorly. In the posterior fourth of the second temporal convolution and the parallel fissure was a depression or cavity, at the bottom of which was a small mass of shrivelled tissue, which was regarded by Dr. Mills as the remains of an old patch of softening. The rest of the temporal lobe was normal, but there was a considerable amount of atrophy around the ascending branch of the Sylvian fissure and the bases of the two central convolutions, as well as in the hinder part of the third frontal. In the right hemisphere was an old hemorrhagic cyst, completely destroying the first and almost completely the second temporal gyrus, the island of Reil, and the convolutions behind, as well as part of the ascending convolutions and of the central substance. The auditory nerves were atrophied, and the stric acousticæ are said to have been invisible to the naked eye. From this case Dr. Mills thinks he is justified in contending that the centre for word-hearing is situated in the hinder thirds of the first and second temporal convolutions, and is possibly restricted to the second; and that although the auditory cerebral arrangements have their chief development in the left temporal lobe, destruction of the opposite centre is necessary in order to abolish hearing entirely. Several minor conclusions are also drawn, but the above are the most obvious.—*Lancet*.

THE PAN-AMERICAN MEDICAL CONGRESS AND THE ROME MEETING.—The fact that the Pan-American and the International Congresses are to meet in the same year, and both of them in the autumn, has given rise to the impression among some that the former was conceived in opposition to the latter. Nothing, we are persuaded, can be more erroneous than this idea,

and we believe that, so far from interfering, the Pan-American will actually help to increase the attendance at the Rome meeting.

The promoters of the Pan-American Congress were at pains to ascertain the date of the Rome meeting, so that there might be no interference, and with this object wrote to Dr. Baccelli several months ago. The latter replied that the Rome meeting would probably be held during the last week of September or the first week of October, although the exact time had not been definitely settled upon. This reply was not received until after the meeting of the Committee in St. Louis, when the date of the Pan-American had been already fixed for the first week in October; but when it was learned that this would interfere with the International, the time was changed to the first week in September. This will make it easy for those who desire to attend both meetings to do so, and is evidence that the Committee of the Pan-American Congress desire to promote rather than to antagonize the International. The Washington meeting must, of course, be held in 1893, in order to afford the opportunity to the Latin-American members of visiting the World's Fair, and the fact that that is also the year for the assembling of the International Congress is but a coincidence, which will, however, be of distinct advantage to both bodies.

The organization of the Pan-American Congress is in the hands of good men; the National Committee is a thoroughly representative one, and the delegates thus far selected from the other countries of the Continent are men of eminence at home, and many of them of an international reputation as well.—*Med. Record*.

DIET IN TYPHOID FEVER.—In the *Medical and Surgical Reporter* (December 5, 1891, p. 889) Dr. Lehlbach emphasizes the fact that typhoid fever is a wasting disease, and calls attention to the researches of Professor Ernst Kohlschütter, who found that a curve representing the waste of tissues in typhoid fever always followed a uniform course, the amount of waste being in direct proportion to the height of the fever. Have we yet found a food which will compensate for the loss? is the question he raises. Only a small part of albuminous foods can be assimilated by a fever patient. A large

detritus is left, therefore, which must greatly irritate the typhoid ulcers if allowed to pass over them. From observations that Lehlbach has made among numerous typhoid stools and at autopsies on several cases, he is convinced that very little of the casein of the milk is really digested, and the other constituents—the milk serum, with its salts, its sugar, and its cream—“form the essential elements of nutritive value in these conditions.” He believes, therefore, that milk is not a perfect food in these cases, and its use should be restricted. He advises the addition of carbo-hydrates to the dietary, such as boiled rice, either with or without milk. “The food thus converted into caloric saves so much of the living tissue from being burnt up.” The dryness of the mouth and tongue, so often present in this disease, is less apt to annoy the patient under such a diet than with milk alone. In addition, he advises giving a small amount of one of the ma't extracts to promote assimilation. His results have been very satisfactory. —*International Medical Magazine.*

THE OFFICIAL INFLUENZA INQUIRY.—We are able to state that the President of the Local Government Board, after consultation with his official medical advisers, has decided, in lieu of obtaining a Royal Commission, to institute a special inquiry—under the direction of the Medical Department of the Board, and, with the aid of its officers and of outside scientific experts, such as Dr. Klein, whose assistance will be summoned—into the clinical characters (symptomatology, causation, mode of diffusion, complications, etc.) and the pathological nature of influenza. The inquiry will proceed on the lines indicated in the last paragraph of Dr. Buchanan's comment on the report of Dr. Parsons, May, 1891, and will include the study of the natural history of the disease, and of more authentic methods of identifying influenza proper from among the various *grippes*, catarrhs, colds, and the like, among men and animals. This may lead to earlier identification of first cases. It will be an object also to acquire better insight into the characters, habits, and conditions of multiplication of the material of influenza, with a view to acquiring by other methods further and better safeguards against the disease. It is felt that our prospects of dealing with in-

fluenza epidemics by isolation and disinfection are not particularly encouraging, and it is hoped we may get suggestions of other methods available for repressing the disease.—*British Medical Journal.*

THE OPERATIVE TREATMENT OF THE ENLARGED PROSTATE.—(1) Prostatectomy is justifiable, and does what nothing else can. (2) The perineal operation is somewhat less severe, but decidedly less reliable than the suprapubic; it should rarely be preferred, unless there be urethral complications. In very feeble men it may still be elected. (3) The operation is not justifiable, with present statistics, if the patient can be comfortable in catheter life. (4) No physical condition of the parts or of the patient short of a practically moribund state contra-indicates operation. By it in desperate cases life is often actually saved, although the operation is a grave one, and its mortality high. (5) With the rongeur—better than any instrument—the bladder outlet can be lowered, and polypoid or interstitial growths jutting into the prostatic sinus can be removed, and these points are more essential to a successful operation than is the taking away of a large portion of the prostatic bulk. The instrument next in value is the curved scissors, but the skilled finger is most important of all. Most of the work has to be done by the aid of touch, as the bleeding soon becomes free and renders visual inspection impossible. (6) Diuretin, perhaps, is of value when the kidneys are damaged. It certainly does no harm. (7) Chloroform alone should be used as an anæsthetic, for the sake of the kidneys.—*Keyes in Med. Rec.*

THE ORIGIN OF THE NAME “GRIPPE.”—In a meteorological journal kept in Versailles, in 1743, it is stated that during the months of February and March there were many cases of nasal and bronchial catarrh, and that “the king (Louis XV.) named this disease *la grippe*.” In the same journal it is remarked that bleeding was not useful, but that those who had not been bled and who drank a great deal recovered much the most rapidly from the attack.—*N. Y. Medical Record.*

THE  
**Canadian Practitioner**

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
 OF THE MEDICAL SCIENCES.

*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.*

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TORONTO, MARCH 1, 1892.

MEDICAL COLLEGES IN NORTH  
 AMERICA.

Certain references were recently made by the *Philadelphia Medical News* which do not show a very intimate knowledge of the merits of a medical training in Canadian colleges as compared with those of the United States. We quote the following from an editorial which appeared in the *News*, Feb. 6th :

"It is true that in the past a comparatively small number of students have come to our leading schools from the South American countries or from Canada. We believe this has been largely because the standard required in our schools and the facilities and equipment provided have not been such as to commend themselves in contrast with the schools of Europe and Great Britain. But, fortunately, just at this time it has been decided that a compulsory four years' course of medical study shall be required at a number of our leading schools, and important improvements also are being made in all the facilities for instruction. There can be little doubt that, if the Pan-American Medical Congress is made as great a success as it should be, all the great schools, from New York to Illinois, will derive valuable results in the form of steadily increasing numbers of desirable students from Canada and the South American countries."

We do not wonder that the *News* feels pleased that a number of "our leading medical schools" (a comparatively small number, by the way) have decided on a four years' course; but we are surprised that, through ignorance or some other unknown cause, it ignores the fact

that a four years' course has been required by some of our Canadian universities for over twenty years. The Ontario Medical Council has demanded such a course for nearly the same length of time, and, under its new regulations, which come into force this year, will require attendance on lectures for four winter courses, one summer course, and, in addition, a fifth year of study, which must include an attendance of at least six months in some hospital or scientific laboratory. It will thus be seen that our requirements for an ordinary medical course have always been in advance of those in the United States. A more important fact still, however, remains to be told: Our matriculation standard is far above the ordinary standard of the United States. We may go farther and say that the requirements for matriculation of the Ontario Medical Council to-day are higher than those of any one college in that country.

The *News* thinks that the number of students who have gone from Canada to its country have been comparatively small. The *News* is right, but does not appear to realize the whole truth, even in this connection. We may tell the *News* that this comparatively small number is, with few exceptions, made up of weak men who go over to our neighboring republic on account of the grand facilities there afforded for running them through a medical course in the shortest and easiest way possible. The weaklings thus rushed through the mills of the United States do not and can not, as a rule, come back to this Dominion to practise, but remain in the country that furnished the cheap and rapid facilities for graduation. There are many magnificent teachers of medicine in the United States, and the large cities of that country are rich in clinical material, and, as a consequence, the excellent post-graduate schools which have been organized in some of these centres attract some of our graduates. While this is true, the broad fact remains that our undergraduate course in our best colleges is equal to, and probably superior to, the best in any city of the United States.

DR. A. H. PAQUET, Professor of Clinical Medicine in the Medical Department of Laval University, Montreal, died recently at St. Cuthbert.

## PHYSICIANS' SIGNS.

There is no absolute law as to the form or size of a doctor's sign, which must depend to some extent on individual tastes. The *New York Medical Record* tells us something about the customs in various parts of the world, as follows: "The fashion in various cities in Europe as to the door-plates and signs of physicians is interesting in its variety. In London a large door-plate of brass or silver is the thing. In Brussels the outside of the house is sometimes decorated à la New York, but generally with more taste. There professional men do not hesitate to announce their specialty. In Berlin, where a celebrated man may be one or more flights up, a porcelain plate neatly inscribed with black letters, sometimes with the specialty, and always with the office hours, is in good form. In Paris there is such an absence of signs or door-plates that it is in many instances difficult to know that you are at the right house, so modest or negative are the indications. In Paris, too, distinguished specialists sometimes live very high up, in great apartment houses without elevators. Philadelphia and Boston outdo New York in the magnitude and splendor of door-plates and office-signs. It is doubtful if they are ever of any particular use, except for those who are looking for a doctor in an emergency, and a very simple indication would be as well as the great sprawling tin, or black marble, or brass affairs that disfigure many a good-looking house."

Those who have watched the evolution of medical sign-growing in this city must acknowledge that in some respects Toronto "beats the record." Our abominations in variety and vulgarity are becoming positively unique. In olden times a plain brass or silver door-plate sufficed. Then came the ugly fanlight with its letters in black, gold, etc. Next in order came window decorations of various kinds. Then in rapid succession the ornamentation extended to walls of the house, gates, fences, conveniently situated trees, etc. The walls of neighbors and finger posts were in due course called into requisition, and signs such as the following are to be seen: "Dr. Wiseman, — doors north." Occasionally a sign, in the shape of a pine board, decorated with the name of some distinguished phy-

sician, and a huge hand with forefinger pointing in the direction of his residence, may be seen nailed to a post on a vacant lot on some of our more remote streets. It doesn't take a man long to find a doctor in Toronto; and if he should happen to miss the physician or surgeon he is quite likely to strike a druggist who is ever ready to treat a fractured skull or a diseased heart. Verily Toronto is twice blessed, if not more so.

## INTERNATIONAL CONGRESS OF GYNECOLOGY AND OBSTETRICS.

Another congress is under way with the above title. The first meeting will be held in Brussels, September 13 to 19, 1892. It is proposed that the congress shall assemble every four years, and it is hoped that the various countries of Europe and America will give it a cordial support. Mr. Lawson Tait has been asked by the committee of management to act as chairman, and has consented to do so. It has been arranged that there shall be three special discussions on the following subjects:

- (1) Pelvic Suppurations. Referee, Dr. A. Legonç, of Paris.
- (2) Extra-uterine Pregnancy. Referee, Dr. A. Martin, of Berlin.
- (3) Placenta Previa. Referee, Dr. Berry Hart, of Edinburgh.

The secretary-general of the congress is Dr. Jacobs, of Brussels, and the secretary for America is Dr. Fernand Henrotin, of Chicago.

## Meeting of Medical Societies.

## TORONTO MEDICAL SOCIETY.

February, 1892.

The president, Dr. A. A. Macdonald, in the chair.

Dr. Allen Baines read the following notes on a case of

## PAROVARIAN CYST.

Mrs. G., aged twenty-five. I attended this lady first in February, 1887. At that time I found her suffering from pelvic cellulitis, caused by cold caught in the sleeping car coming from Montreal. She had her menses, which commenced the day before starting. The flow was stopped and she felt some slight pain. Cohabitation with her husband was tried, but the intense pain she suffered caused him to desist. Next day he sent for me. I found her in a high fever, rapid pulse, etc., all the regular symptoms of inflammation—great

tenderness of the abdomen, low down—and examination per vaginam almost impossible from the acute pain the slightest touch caused her. Under appropriate treatment she recovered. She never became pregnant, and marital relationship was normal until six months ago. However, from the time of this cellulitis she was never quite herself, and came to my office occasionally, complaining of some slight pelvic pains. The uterus was movable, though tender. The tubes and ovaries seemed normal. Being anxious to have children, I dilated the os and cervix with electric dilators, causing no pain, until I could put my little finger up the canal. However, this did no good. Four months ago she began to have extremely painful periods. I never saw any one suffer such agony. I gave all sorts of drugs with no avail. Morphine she could not or would not take on account of the prolonged and distressing nausea. After the last menses I examined her very carefully, and found a cyst on either side, which felt like a much enlarged tube. I called Dr. Temple in consultation, and he agreed with me that operation was necessary at once, we both thinking it was a case of pyosalpinx.

We operated on Saturday last. On opening the abdomen, I found a perfect roof of old dense adhesions, which gave me a great deal of hard digging, accompanied by profuse hemorrhage, ere I could arrive at the tube. At length I got the tumor clear, and found it to be a parovarian, about the size of a hen's egg. In trying to clear the end of the tube from its adhesion to the side of the pelvis, I broke the cyst, which contained clear, limpid fluid, as is found generally in parovarian cysts. The hemorrhage becoming free, we tied in two places and removed the tumor, leaving the fimbriated end *in situ*. The patient here became somewhat collapsed. The left side was not covered with such dense adhesions, but was quite large—as big as a turnip. This was easily ligated and removed, and turned out to be an ovarian cyst. Our attention was now turned to the oozing, which was considerable, from the first pedicles and broken adhesions. We tied many, washed out, and put in a drainage tube before making the abdominal toilet. I sucked out with a syringe the tube, and found pure blood coming up. It seemed a question whether or not to reopen and plug the pelvic cavity with gauze. Here a lesson may be learned. I stayed three hours with her, using the syringe every half hour, each time bring up  $\bar{\text{viii}}$  pure blood. Naturally, I was most anxious, and at 9 p.m. had a consultation with Drs. Temple and Macdonald. The oozing was as great as ever, and the patient in great pain. We resolved not to open, but to keep the syringe going every half hour. To still the pain, we gave forty grains chloral by rectum; morphine, from her peculiar antipathy, being out of the question. She had a very bad night, suffering great pain, eighty grains chloral having no effect whatever. Next morning we met again at 10 a.m. I then bethought of etherodyne, a most invaluable preparation of opium; it does not cause vomiting as a rule, and acts rapidly. I gave her twenty minims every hour for four hours, when she went off into a quiet sleep, and has had since no pain whatever. The oozing continued all Sunday, lessening towards night. On Monday it was reddish. Tuesday, all that came was a little pale straw-colored serum, so I removed the tube. She was a

little tympanitic; I ordered  $\bar{\text{ij}}$  gr. calomel every hour, which had the effect of bringing away flatus, but no movement;  $\bar{\text{vii}}$  magnes. sulph. every hour followed. This had no effect. Injected  $\bar{\text{vii}}$  cl. R. and  $\bar{\text{ii}}$  glycerine, which caused copious movements with any amount of flatus. After this the temperature fell to 99  $\frac{1}{5}$ ; pulse, 96. She is hungry, and seems to be going on caputally.

Dr. J. F. W. Ross showed the following specimens:

#### VAGINAL CYST ANTERIOR.

The first specimen is one of some interest, chiefly on account of the error made by a former attendant upon different occasions. He told her that she suffered from a prolapse of the bladder, and that nothing could be done for her. The operation was done after the method of Schroeder, owing to the proximity and intimate connection of the cyst to the urethra.

Case of acute general peritonitis, caused by rupture of a secondary suppuration in an old clot left after intra-abdominal rupture of an extra-uterine gestation. Operation. Recovery.

The patient was seen by me in consultation with Dr. Cuthbertson. Under chloroform a mass was felt in that situation supposed to be so characteristic of parametritis, close to the uterus, between the uterus and the bladder. She had suffered from pain, and had then been laid up with peritonitis. Never missed a month more than a few days. No excessive uterine hemorrhages. I advised removal to the hospital, so that I could watch her. After being in the institution for about a week, she took a pain in the old region. It was not very severe. I saw her and found the temperature up a little and pulse also somewhat elevated. Owing to family sickness, I was unable to visit her for two days. When I called in casually on Friday afternoon, I found her very ill. On Thursday she had a chill: temperature, 103; pulse, 110. Her abdomen was now tender all over. No distension as yet. I gave orders that I would open her abdomen at 9.30 Saturday morning. I diagnosed a ruptured pus sac and general peritonitis.

On opening the abdomen, I found it full of pus and the perivis full of grumous blood and matter. I peeled off the sac by means of two fingers in the vagina and two in the abdomen. I show it here to-night. It has been examined microscopically and proves to be a tube, the seat of an old gestation with the placenta still *in situ* and a semi-organized clot, looking at its edges like the corrugated wall in the *corpus luteum*, and showing the source of the pus that ruptured into the abdomen. The case is one of extreme interest. The patient made a rapid recovery.

The next specimen is a uterus, the seat of three myomata removed by abdomino-vaginal method. The operation was exceedingly difficult. Two years ago I removed the ovaries and tubes from this patient, but failed to relieve her hemorrhages. At that operation the uterus was firmly bound down, though small. It is now no larger than a large orange. I knew, from careful digital exploration of the uterus, that the tumors could not be satisfactorily removed, and considered that the new abdomino-vaginal method of total extirpation would give her the best chance for her life. Vaginal hysterectomy was out of the question, owing to the adhesions, and abdominal hysterectomy

tomy could not be carried out because the uterus was too small. The new operation had in this case one that could not be done by any other method. The patient made an uninterrupted recovery. I intend reporting this case at greater length elsewhere.

The next specimens are small pus tubes and a degenerated ovary from a patient suffering from profuse uterine hemorrhages. The left ovary was nothing but a blood cyst. She has made a good recovery.

Dr. Ross then narrated the following history of a patient on whom he had performed the operation of

#### CHOLECYSTOTOMY.

Mr. C., aged fifty-five years, a policeman in England until he came to this country a few years ago. While in England he had five attacks of colic. The first one affected him fifteen years ago. It came on suddenly one night, and was not therefore connected with the ingestion of food, or with any injury. The pain was referred to the epigastric region, and accompanied by vomiting. It lasted but a short time. He felt weak for a day or two, and was then as well as ever. There was a considerable interval between the attacks. He had tenderness under the margin of the liver after each attack.

For two weeks he has had continuous pain, and has begun to feel very wretched.

On examination, an indistinct tumor can be felt moving back and toward the median line among the intestines. It evidently has its attachment above. Dr. McMahon asked me to see the case. He thought that the symptoms pointed to the presence of gall stones. I agreed with his opinion, and advised operation. The patient consented.

*Operation.*—On opening the abdomen, the gall bladder was found distended like a large sausage. On puncturing it with a trocar, the starch-like fluid usually found in these cases escaped. It was not in the least tinged with bile. Forty-four stones were then removed from the gall bladder, and one was felt impacted in the cystic duct. From within the gall bladder this could merely be touched with the finger nail. Efforts to crush it from within were unsuccessful, and manipulation on the outside of the duct could not dislodge it. I therefore incised the duct directly over it, and the stone was easily removed with a small scoop. It was firmly fixed, and reminded me of a small snake that has swallowed a large toad. Bile gushed out of the duct and was caught on a sponge. The duct was then closed by means of two Halstead sutures. A drainage tube was placed in the abdomen over the duct, and one was also placed in the gall bladder. The bladder was fastened to the abdominal wall.

Bile escaped freely for twenty-four hours through the upper tube, and must have proceeded from the incised duct. This then ceased and large quantities of bile were vomited. The common duct was doing its work. On the fifth day the sutures were removed. On the third day the tube was removed from the abdomen, but a drain of iodoform gauze was passed down to keep the track clear for a few days longer.

The patient is doing well. Bile is coming from the gall bladder.

Dr. Ross also read the following notes of

#### AN OVARIAN TUMOR IMPACTED IN THE PELVIS.

Mrs. H., sent by Dr. R. A. Pyne in October, 1889. I examined her in consultation, and found the uterus evidently the seat of an outgrowth. The uterus and the outgrowth moved together. The mass felt hard; no fluctuation could be made out under chloroform. However, there was an element of doubt on account of part of the history. The patient was unwell regularly, had been married ten or twelve years, had never been pregnant, and never had gonorrhoea. Shortly after her arrival in Canada she consulted a physician, who told her that the womb was enlarged and that she must be pregnant. Owing to abdominal pains, she at length consulted Dr. Pyne. I felt some doubt about the nature of the tumor, and advised exploration. A day or two after her removal to the Woman's Hospital a swelling presented itself in her left groin. The temperature became elevated, and I opened a large abscess that led down to the side of the uterus, apparently into the left broad ligament. After this had contracted, so that only a small sinus was left, the patient insisted on going home. I then, from time to time, endeavored to heal the sinus, but without avail. Complaining again of pain some months after this, she again came into the hospital for a short time, but now I felt so sure that the tumor was a fibroid from so many examinations that I felt sure that nothing but a desperate hysterectomy would cure her. She again went out, refusing to run any great risk, and I lost sight of her for many months. She again came back, with the old sinus still running, but looking the very picture of health. She had suffered so much pain that she had made up her mind either to "be quit of her tumor, or quit of the world," as she expressed it. A week ago I prepared the patient for abdomino-vaginal hysterectomy. After placing her in Trendelenburg's position, I made a good, free incision. The first thing encountered was a large intestine firmly adherent, and matted so that no headway could be made. A portion of the anterior and lower surface of a fluctuating mass could be reached by raising up the bowel. Was this bladder? A sound soon settled the question in the negative. The uterus could not be reached. I examined with the fingers of the left hand in the abdomen, and the fingers of the right hand in the vagina. The same hard mass could be felt, but the uterus could not be readily made out. I asked one of the medical gentlemen present to examine, and he said that he also felt a fibroid tumor. I then tapped the cyst, and after two hours of hard and anxious work managed to enucleate from its bed of dense adhesions an ovarian tumor about the size of a large orange. The adhesions to the uterus were so dense that I had to apply ligatures to several vessels about the left uterine cornu; and the rectal and bowel adhesions were in many places tied off in sections. An inner and an outer pedicle were formed, so as to avoid injury to the rectum and ureters.

The patient has done splendidly. I took out the stitches to-day. This case is now the second in which I have diagnosed fibroid tumor of the uterus after repeated examinations (and the use of the sound, to please those who pin their faith to it), and in which I have been unable to confirm my diagnosis by abdominal exploration.

Tait told me of a lady who consulted eminent men in Chicago, New York, Vienna, and London. They all told her that she was suffering from a uterine fibroid, but advised against operation. Her pain was annoying. She went to Tait. He told her that it might be a fibroid tumor, but it might not. She told him to go on and find out what it was. He did go on, and while I was with him removed a small dermoid cyst impacted in the pelvis. She went home delighted. The men who are "cock sure" in the pelvis are the ones who are most frequently wrong in their diagnosis.

#### GYNÉCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

##### January meeting.

The president, Dr. Wm. E. Moseley, in the chair. Dr. T. A. Ashby exhibited a specimen of dermoid cyst which he had recently removed from a single woman twenty-five years of age.

The cyst grew from the left ovary, and had been diagnosed as ovarian cyst. It measured  $4\frac{1}{2}$  by  $5\frac{1}{2}$  inches in its diameter. Its removal was accomplished without trouble, and the patient made a prompt recovery.

The interest in the case centred in the character of the cyst, and its contents. It was lined internally with a dermal tissue, and at one point the layer covered a small piece of bone. At this point a long twist of hair grew from the skin and measured thirty inches in length. The cyst contained a large collection of sebaceous and oily matter, and large strands of hair disconnected from the tumor and matted together in the cyst.

The specimen is an uncommon variety of dermoid cyst. A similar case has been reported by Dr. Munde, of New York. Dr. Ashby referred to the origin of dermoid tumors.

They are, no doubt, due to an irregular development of the epiblastic layer of the tissues of the fetus in embryonic life. The cysts are almost uniformly found in organs and tissues which owe their origin to the layer of the epiblast, and this circumstance goes to explain the peculiar features which they present. The ovary is a very common location for them, and this fact would tend to prove that the organs of generation originate in the epiblast.

Dr. Wilmer Brinton read a paper on "Twin Pregnancy, Complicated by Placenta Previa Centralis."

I was summoned at 3:30 o'clock on the morning of September 1st, 1891, to see Mrs. B. T. M. Her second confinement, from her reckoning, would take place on October 15th.

I did not see her until sent for, as stated, on the morning of September 1st. Upon arriving at her home, I found my patient in bed, with the history of being awakened some time before I was sent for by having a few sharp pains, which were followed by a profuse hemorrhage.

Upon examining Mrs. M., I found the vagina filled with large clots of blood, the os slightly dilated and very soft, and a placenta presenting. At this time, her pains having ceased, I cleaned out the clots from the vagina, and found the bleeding had stopped.

I determined to return home, which I did, leaving orders for my patient to remain quiet, and to send for me at once if the pains or bleeding returned.

I was informed, before leaving the house, that a week previous the patient had had a severe hemorrhage, and, knowing I was out of the city, Dr. W. J. Jones, who lives in the immediate vicinity, was sent for. He saw her twice, and under the treatment and advice which he gave her the bleeding ceased.

At 6:30, or about three hours from the time I left the house, I was again sent for. I immediately responded, and I was soon joined, at my request, by my colleague, Dr. Crouch, and by Dr. J. H. Robinson.

A vaginal examination made at this time found the vagina filled with blood, which was continuing to flow. The os was more dilated and dilatible than it was at my previous examination, and a more complete examination found the placenta presenting, which was of the most complete central variety which I have ever seen. In running my finger around, I found the placenta was completely attached to the mucous membrane of the lower segment of the uterus, with the exception of a small space on the left side, from which the bleeding came, and in which a tear had taken place during the recent contractions, which had severed a small portion of the placenta from the attachments. My opinion being verified by the gentlemen present, and as the hemorrhage and pains were continuing, we determined to deliver at once. Chloroform was administered, and introducing my hand I found the cervix not well dilated, and had some trouble in introducing my hand. I tore rapidly through the placenta at the left side, and found a child presenting vertex. I ruptured the bag of water, and delivered it living by podalic version. In my efforts to do this, I was made conscious, for the first time, that the uterus contained a second child; so tying the cord of the first child, and handing it to Dr. Crouch, who was ably assisting me, I introduced my hand for the second time, and found the second child presenting shoulder—dorso-anterior position—the head being to the mother's left. I turned and immediately delivered a second living child, after which I introduced my hand into the uterus and removed the placenta, which presented a very ragged appearance from my efforts made in passing it at its attachment to the uterus on the left side. After removing the placenta, the vagina and the uterus were thoroughly washed out with warm water, during which I discovered the cervix was lacerated on both sides, due, no doubt, to my efforts to deliver the children through an imperfectly dilated cervix. Although a large amount of blood was lost during the operation procedures, the woman rallied well from the chloroform, the uterus contracted well, and within a few hours our patient presented no special traces of the severe ordeal which she had passed through. The children born, both males, presented the appearance of having advanced to the seven and a half months utero-gestation, and for two or three hours after birth did well, but later on in the day their extremities became cold, lips blue, heart weak, and they died some seven hours after their birth.

The mother did fairly well for a week, although

the pulse and temperature were somewhat above normal—the pulse averaging between 90 and 100, and the temperature about 100. She sat up on the eleventh day, and on the following day I was sent for, and found her with a high temperature and a rapid pulse, with some indication of phlegmasia alba dolens, and for three weeks she was under my constant care, with evidence of well-marked septic complications, and as soon as the tendency for phlebitis disappeared in one leg it appeared in the other.

I am satisfied the late septic complications occurred from the lacerated cervix, which healed up kindly on the right side, but not so on the left, which healed slowly by granulations.

Upon my recall to the case on the eleventh day, I took charge of the vaginal injections myself. Previous to this time I had entrusted this to the nurse, much to my regret, for upon my first examination I was satisfied they had not been thoroughly given; so every day for several days I introduced a speculum, and with an ordinary piston syringe I washed out the uterus, the cervix, and the vagina with bichloride or carbolic acid sol., and dusted the seat of laceration with either boracic acid or iodoform. Internally was given quinine, phenacetin, large doses of iron, and good food.

The leg was bandaged from time to time with an ordinary roller bandage. Greatly to my relief, my patient finally recovered, and seven weeks after her confinement returned to her home in Washington.

My object in reporting this case is to impress on the minds of physicians the importance of not temporizing when they have to do with a case of placenta previa. There is no safety for the mother as long as she remains undelivered. I am satisfied no one can lay down dogmatic rules in every individual case, but my personal experience has taught me that in performing podalic version, and delivering either rapidly or slowly, as the case may indicate, you are working for the best interests of the mother and child in the vast majority of cases.

Dr. Wm. P. Chunn: I have seen only two cases of placenta previa. One I saw with Dr. Neal. The patient had been tamponed with cotton. He took out the cotton, inserted his left hand, and delivered the child by podalic version. Both mother and child did well. I had one patient of my own. It was a marginal implantation, and I thought I could use the forceps better than turn, and I did so. I had some difficulty in getting the forceps on, and failed at first; but the attending physician forced the head firmly down by external pressure, the forceps were put on, and the child delivered. I think I might have done better by podalic version.

Dr. Brinton: There is no absolute law for the treatment of placenta previa. In my first case the patient was lost by delay. In another case, the woman had bled considerably, but about the time I was called the head came down and the bleeding stopped. Forceps were put on and the child delivered. I am now satisfied that the first patient could have been saved by prompt action. In the ten cases of placenta previa which I have seen in practice, only two of the children have been saved. The mothers have all recovered with the one exception, as already specified.

Dr. T. A. Ashby: I think Dr. Brinton did the

proper thing in this case. My experience with these cases has been limited, having seen but two. In one the child was dead born. The mother recovered. The placenta was attached over the entire cervix, and had to be torn away before the child could be delivered. In the second case I removed a dead fetus of five or six months with placenta previa. She had been bleeding for some weeks. She recovered, and subsequently gave birth to a living child. More recently I delivered her of another dead fetus.

With reference to the septic trouble which the doctor's patient had suffered from, I am satisfied that lacerated cervix is a prolific cause of pelvic troubles, and I frequently find laceration of the cervix and involvement of the tubes associated. The treatment that the doctor suggested, of going into the uterus and washing it out thoroughly, is very good. My own method is somewhat different. I put in a speculum, fill up the vagina with a bichloride solution, and then with some cotton on an applicator remove all the debris from the cavity of the uterus. I have treated eight cases in this way in the last year, and in each case got a good result.

I have seen but one case of pure septicemia that came on four weeks after confinement. There were no local lesions, and there was nothing in the uterus to be removed. The symptoms came on the twenty-first day after confinement, and she died in about a week.

## Personal.

H. H. OLDRIDGE, M.B. Univ. Tor. '91, has returned from the West Coast of Africa, and has sailed from London for New Zealand, as surgeon of the "Duke of Sutherland" (3116 tons), one of the Ducal Line of steamships.

LORD KELVIN is the title which the newly-created medical peer, Sir William Thompson, will adopt. That is the name of a river that empties into the Clyde at Glasgow.

## Therapeutic Notes.

DANDRUFF.—The following pomade is recommended in the treatment of dandruff:

R.—Acidi salicylici	- - -	ʒss.
Sodii boratis	- - -	gr. xv.
Bals. peruviani	- - -	ʒ xxiv.
Ol. anisi	- - -	ʒ v.
Ol. bergamot	- - -	ʒ xv.
Vaselini	- - -	ʒ iij.

M. et ft. unguentum.

THE TREATMENT OF ASTHMA—I divide cases into acute and chronic. In the *former*, marked by the most severe and urgent symptoms, I give carbonate of ammonia (5 grains), iodide of sodium (2 grains), tincture of belladonna (10 minims), and medium doses of aloës every hour or two. I also prescribe a ten-grain powder of antifebrin to be taken first. Asthma being, pathologically considered, a venous stasis in the bronchial tract, the ammonia, antifebrin, and sodic iodide flush the veins by their fibrin-solvent and liquefying action; the ammonia and belladonna stimulate the heart and dilate the peripheral capillaries; and the aloës act as a derivative of the blood-current toward the intestines and away from the bronchial tract. In the *chronic* form, marked by much less urgency, and generally accompanied by a degree of chronic bronchitis, I find astringent iron preparations, with full doses of belladonna, answer well.—*Satellite*.

NIGHT-TERRORS occur usually, but not invariably, in delicate neurotic children. The direct cause is usually undue stimulation of the brain, or of the imagination, by exciting stories, unkind treatment, a visit to the zoological gardens, or overpressure at school. By far the most common cause, the author believes, is constipation, often slight but persistent, the stools being hard and dry, and usually of light color. The error in the management of these cases is the use of sedative treatment, the constipation being neglected. The neurotic element alone being recognized, bromides are prescribed, often with good effect for the time. The cause being allowed to remain, the relief is in many cases temporary.—*Cheadle—Practitioner*.

ATROPINE IN LEAD COLIC.—Dr. F. Rowland Humphreys reports in *The Lancet* for November 21st, 1891, a number of cases of lead poisoning treated successfully with sulphate of atropine and iodide of potassium. The author concludes that in lead poisoning atropine in full doses (1) relieves the colic and the pain in the head in the most rapid manner; (2) it keeps the bowels freely open; (3) it assists in the return of the bodily powers; (4) it assists, directly or indirectly, in the removal of the lead by iodide of potassium.—*N. Y. Medical Record*.

SOLUTION OF THE FOUR CHLORIDES.—Formula of Dr. W. Goodell (*Am. Jour. Phar.*):

R. Hydrarg. bichlor. corros. gr. j.  
Liq. Arsenici chl. . . . . m℥viii.  
Tinct. ferri chloridi  
Acidi hydrochlorici dil. aa ʒiv.  
Syrupus zingiberis q. s. ad, ʒiij.

M. Sig.—One-half to one teaspoonful in water after meals.

This preparation is being prescribed quite frequently, and several formulæ disagreeing with each other have been published. The above is an exact copy of the formula recently received direct from Dr. Goodell.—*Weekly Medical Review*.

INFLUENZA COLDS.—Few remedies are more reliable, and act better as a preventive, or lessen the distressing symptoms of an influenza cold, than the following mixture:

R Sodii salicylas . . . . . ʒjss.  
Liq. ammon. acet . . . . . ʒij.  
Aq. camph. . . . . ad ʒvj.  
Misce. Capt.: ʒss. omnis 3tiis horis.

If this be taken every two or three hours, when the first symptoms of cold come on, it will usually ward off the attack.—*British and Colonial Druggist*.

FOR sciatica, Dr. Starr ("*Nervous Diseases*") suggests:

R. Tinct. colchici,  
Tinct. cimicifugæ,  
Tinct. aconiti,  
Tinct. belladonnæ. aa mʒ¼. M.

Sig.—One dose.

—*College and Clinical Record*.

SOLUTIONS of sublimate, heated to the temperature of 37° 8' C. (100° F.) or over, have their antiseptic properties rendered more energetic by the elevation in temperature; thus a solution of 1 : 1000 will, under these conditions, possess a germicidal action equal to a cold solution of 1 : 500.—*Medical Age*.

QUININE cost \$20.00 per ounce in 1823, and \$3.00 in 1853; \$3.70 in 1878; while now it costs from 18½ to 24 cents.

SALICYLIC ACID is said to cause a marked diminution in virile power.

## Miscellaneous.

**NEW MEDICAL WORKS.**—Mr. Saunders, publisher, of Philadelphia, makes the following announcement: Important new medical works now in preparation, ready for delivery about June 1, 1892: (1) *An American Text-Book of Surgery*, by Professors Keen, White, Burnett, Conner, Dennis, Park, Nancrede, Pilcher, Senn, Shepherd, Stimson, Thomson, and Warren, forming one handsome royal octavo volume of about 1,200 pages (10 x 7 inches), profusely illustrated with wood-cuts in text and chromolithographic plates—many of them engraved from original photographs and drawings furnished by the authors. Price—cloth, \$7.00; sheep, \$8.00. (2) *An American Text-Book of the Theory and Practice of Medicine, according to American Teachers*, edited by William Pepper, M.D., LL.D., provost of the University of Pennsylvania, to be completed in two handsome royal octavo volumes of about 1,000 pages each, with illustrations to elucidate the text wherever necessary. Price per volume—cloth, \$5.00; sheep, \$6.00; half Russia, \$7.00.

**TO PREVENT GROWTH OF FUNGUS IN SUGAR SOLUTIONS.**—Mr. Leon C. Fink has carried out some experiments to determine exactly what proportion of salicylic acid is necessary to prevent growth of fungus in dilute aqueous solutions of sugar (*Bulletin of Pharmacy*). He finds that one-half grain of salicylic acid in each ounce of a one to three solution of sugar is an absolute safeguard against the formation of fungus, the liquid having remained perfectly clear and transparent after exposure for one year.—*Amer. Jour. of Med. Science*.

**A SMART TRICK.**—A Canadian medical student recently smuggled a skeleton into Canada from Detroit by dressing it up, properly padded, in woman's clothes, putting on it a hat and a thick blue veil, and seating it alongside of him in a buggy while crossing the ferry. After he had got it by the customs officers and into his own house, he learned that there was no duty on skeletons. His opinion of his own cleverness has fallen a degree or to.—*N. Y. Medical Record*.

**A CHEAP DISINFECTANT.**—Nitrate of lead is the cheapest disinfectant known that fulfils its intent. It does not, however, prevent putrefaction. The chloride of lead is much more effective in all directions. It is made by dissolving a small teaspoonful of the nitrate of lead in a pint of boiling water; then dissolving two teaspoons of common salt in eight quarts of water. When both are thoroughly dissolved, mix the two solutions. When the sediment has settled you have two gallons of clear fluid, which is a saturated solution of chloride of lead in water. A pound of nitrate of lead will make several barrels of the liquid, and costs from eighteen to twenty-five cents at retail.—*Annals of Hygiene*.

**THE PAN-AMERICAN MEDICAL CONGRESS IN NEW YORK STATE.**—At a meeting of the Medical Society of the State of New York at Albany, Feb. 5, a committee was appointed to co-operate in promoting the interests of the Pan-American Medical Congress. The committee consisted of Drs. A. Walter Suiter, A. Vander Veer, James D. Spencer, Seneca D. Powell, W. W. Potter, D. B. St. John Roosa, and John O. Roe.

**SUICIDE AMONG PHYSICIANS.**—The *Boston Medical and Surgical Journal* tells us that physicians not only headed the list of suicides last year, but that they have headed it every year in the last ten. This promises to be still more conspicuous this year, as in the first twelve days of January no less than seven physicians committed suicide in the United States.

**PRIZE OF THE SOCIÉTÉ MÉDICALE DES HÔPITAUX.**—The Hospitals Medical Society of Paris offers a prize of 1,000 francs (\$200) for the best essay upon "Artificial Feeding of Infants." The competitive papers must be sent to the secretary of the society not later than July 1st, 1892.

**COUNTERFEIT MUMMIES.**—Seventeen mummies, recently purchased at a cost of \$200,000 by the Berlin Museum, have been shown to be of recent manufacture and the handiwork of some wily Arabs of Alexandria.

A SCOTCH hospital is to be erected in Chicago as a memorial of Robert Burns.