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THE CANADA MEDICAL RECORD.

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CONTENTS.

Original Communications.

CASE OF TUBAL GESTATION.

By DR. CARR HOLSTOK ROBERTS, L.R.C.P., Lond., M.R.C.S.E., L.S.A., London.

In the November number of the "RECORD" for 1882, I reported a case of Interstitial Gestation which terminated fatally at the end of the second month, from spontaneous rupture of the sac; perhaps the following brief history of a case which ran through and beyond the full period of ordinary gestation may not be uninteresting.

Mrs. C., æt 35, a middle-sized, intelligent woman, with a healthy physique, who had been married many years, but had never had any family and had never miscarried, consulted me on the 4th June, 1885, suspecting that she was *enceinte;* catamenia (which, as a rule, were always pretty regular) ceased on the 4th March; all the usual signs of pregnancy were present, and with the exception of the abdomen being very much larger than is usual at so short an interval, there was nothing to indicate its being anything more than an ordinary case. I considered her to be pregnant, but that there might be a tumor of some kind in addition, and I advised her to wait patiently the course of events. I saw her from time to time, and she continued to increase in size, and the first week in August she felt fœtal movements. On the 4th October she again consulted me, having most unfortunately contracted syphilis, which yielded to Iodide of Potassium (she was not mercurialized); but she rapidly lost flesh, the abdomen increased greatly in size, but the "swelling dropped," repeated digital examinations failed to reach the os, nor could a sound be passed; but early in October fœtal movements could be distinctly felt and seen, and the fœtal heart heard. She suffered the first week in November from a sharp attack of subacute peritonitis, which left her very prostrate and very much emaciated, and she became subject to attacks of most acute pain which were only controlled by Hypodermic injections of Morphia, there had been for some time lacteal fluid in the mammæ, she also complained of "crackling in her inside like the crackling of parchment." I came to the conclusion that it was a case of Interstitial Tubal Gestation, and asked Mr. Alban Doran to see the case with me, which he kindly did on several occasions, on one of which he succeeded in reaching the os and finding the uterus empty, it was decided to wait until the ordinary nine months elapsed, and she was removed to the Samaritan Hospital, on the 17th February. Sir Spencer Wells kindly met us in consultation, and it was decided to operate as soon as a bad bed sore, which she unfortunately had, should be somewhat improved. The operation was performed on the 26th March, 1886, and on opening the abdominal cavity, a large tumor was exposed, with a shiny, smooth surface of a dark red color; it was tapped but neither fluid nor blood escaped. Fearing that the tumor might be a malignant growth, and as no fœtus could be felt through the anterior wall of the tumor, Mr. Doran, assisted by Dr. Bantock, cleared away adhesions, which were very intimate posteriorly; in so doing the transverse colon and sigmoid flexure were lacerated, and required suture. The cyst, when raised, burst on its right side, and

then the fœtus was seen and removed, a wire clamp was passed round the root or base of the tumor, and a drainage tube was passed into Douglas' pouch ; there was little or no hæmorrhage, but a considerable amount of shock, and the patient succumbed the following night. The uterus, placenta, and other parts removed are at present being dissected, and the result I hope to make known to to your readers at some not very remote period; but I may incidentally remark that the fœtus, a full grown and remarkably fine male child, was not in the least offensive or decomposed, but entire and in a very good state of preservation. There was no doubt about the pregnancy being tubul, and altogether the case was a very remarkable one amongst these fortunately rare cases. Whether an operation if performed earlier would have been more successful, what share the syphilis had in impairing the mother's health, and what was the cause of the peritoneal inflammation, are problems that require a good deal of solving. The length to which gestation extended, the remarkable state of preservation in which the infant was, and the very great state of emaciation to which the mother was reduced, she was quite a skeleton, are very remarkable features in this very remarkable case. I omitted to say that the specimen referred to in November, 1882, was sent to the museum of the Royal College of surgeons, and is, I believe, the only perfect specimen in that or any other museum.

LONDON, 60 Haries St. W., April, 1887.

GYNÆCOLOGICAL REPORT.

By E. H. TRENHOLME, M.D., C.M., B.C.L., Professor of Gynecology, Medical Faculty, University of Bishop's College, Montreal.

VICARIOUS MENSTRUATION.

A most interesting discussion aroused upon this subject has lately appeared in the *British Medical Journal.* Dr. Barnes read a paper upon the subject, which was marked by his usual ability, and in which he related a number of cases illustrative of the views generally held, and currently accepted as to the truth of vicarious menstruation.

Dr. Wilkes, who was present at the reading of the paper, by invitation of Dr. Barnes, made a remarkable address in reply to the views advanced, and expressed his adherence to views he had already advanced, as to the sure existence of vicarious menstruation. Dr. Wilkes said his scepticism as to the existence of an affection, long accepted and taught by lecturers and writers upon diseases of women, arose from personal investigation of the supposed cases, in every one of which he found that the positive assurance of patients and friends as to the periodicity of the bleeding was erroneous. This statement was followed up with an examination of the cases reported by authors, in which he brings before us their paucity as to numbers, and more liability as to fact. This quite startles one, but, nevertheless Dr. Wilkes' position seems well taken, and he can only be dislodged therefrom by the force of authentic and carefully reported cases. So far, he says *no one* has "given a straightforward and simple case of a girl bringing up blood every month, of the truth of which there could be no reason to doubt the accuracy." After referring to the view of some, that amenorrhœa is a substantive disease, he expresses his opinion that in an enormous majority of cases, it is a symptom and a consequence of disease elsewhere ; not only is the outward discharge wanting, but as the physiological process itself is in abeyance, there is no room for the process of so called vicarious menstruation. In conclusion, Dr. Wilkes says he does not deny the disturbance which often takes place during the menstrual period, and that an hysterical woman would spit up blood, or that an ulcer of the leg might put on a different action; but that this is different from saying that the processes connected with menstruation take place through the leg.

ANTISEPTIC IRRIGATION.

Dr. Cushing has drawn the attention of the profession to the importance of vaginal irrigation in all operations upon the womb. He states that the vagina is a very hotbed for bacterial colonies, and that in a great many cases, even in the best society, an old and unnoticed gleet in the husband has given rise to a mild and forgotten gonorrhœa in the wife, so that gonocci and other pathogenic germs may abound in the vagina, ready to be carried into the uterus on the sound, or get into any abrasion or cut made by the surgeon. As the sublimate solution, which is the best for destroying the bacteria, does not keep well in water, it is best to prepare it fresh daily. For private practice, losenges, containing 7- 1-3 grs. of sublimate, combined with ammon. chlor., make a quart solution of 1-2000. For hospital use ʒ ij corrosive sublimate to ℥ i glycerine keeps well, and by mixing ʒ j of this solution with two quarts of water gives 1-2000.

GYNÆCOLOGICAL THERAPEUTICS.

Under this heading, Dr. Currie draws attention to the value of some of the means available for the relief of female diseases, and thinks that a very considerable portion of diseased conditions may be treated without the knife, and in place of divulsions, incising the neck, and intra-uterine applications, we should substitute a regimen of rest, diet, rubbing, exercise, etc., and only resort to surgical procedure when these means fail. The author then refers to laparotomy, and refers appprovingly to the actual cautery as a useful means of preventing sepsis and hemorrhage from the stump.

In hysterectomy the V shaped incision is approvingly spoken of, and the credit of the operation properly given to Schroeder, though the question of priority of the operation may be in doubt, inasmuch as Dr. Trenholme of this city suggested the operation some 12 years ago. Schroeder's advice to operate upon cancerous uteri and ovarii is perhaps open to question, in fact will not be accepted if the results following the operations on this side of the ocean are to guide us.

NEW THEORY OF MENSTRUATION.

Dr. Johnston, of Danville, Kentucky, regards menstruation as a result of a glandular function, and that the menstrual organ is the endometrium. He finds the coating of columnar epithelium in young girls devoid of *corpuscular development;* at 13th year there is a more elaborately developed columnar epithelium, and the beginning of a corpuscular layer; while at 20 there is an abundant corpuscular development, forming a thick endometrium with its endometrium in process of removal; while in a woman of 60 there was little endometrial structure, and almost complete absence of corpuscular element and total absence of epithelium. Dr. Sutton "of Liverpool" agrees with Dr. Johnston, that the epithelium of the tubes is not shed during menstruation. The facts thus established shew that the activity of the ovaries is co-equal with life, while that of the uterus is limited to the period between puberty and the climateric, and it is during this period only that uterine myoma can be developed.

These resources, though helpful, and doubtless correct as a general rule, yet fail to explain cases of menstruation where the fallopian tubes were impervious, and the uterine cavity was entirely concluded by the coalescence of the endometrium, as in a case reported some 2 years ago, by Dr. Trenholme, and uterus exhibited before the Medico-Chirurgical Society of this city.

Correspondence.

LETTER FROM NEW YORK.

NEW YORK, April, 1887.

DEAR RECORD,—Although there is no place in the world where Gynecology has reached such a high stage of perfection, yet for the general student, in this popular branch of our art, there is little chance here of advancing his studies, owing to the restrictions with which are surrounded the physicians of the various institutions where the diseases of women are treated. The staff receive you with the greatest courtesy, invite you to hysterectomies and ovariotomies, to operations for lacerated cervix, and for lacerated perineum, but to take you into the wards or out-patient rooms when they are diagnosing and treating ordinary cases, is a thing which they have not the power to do; it being against the rules to have more than two men in the room while a woman is being examined, and those two are the doctor and his own assistant. The best plan is to take out a special ticket at the Polyclinic, where, of course, there are no restrictions as to the number of students present. At the Woman's Hospital, corner 49th and 4th avenue, the operations take place at 2 p.m. sharp, nearly every day.

At this institution I spent a pleasant afternoon with old Dr. Emmett. There was a difficult case of vesico vaginal fistula to be operated upon, and as he was not feeling very well he handed the instruments over to his nephew, Dr. Baebe Emmett, while he made running commentaries on this and other cases. He told us that the whole of the urethra and all the lower surface of the bladder, as far as the openings of the ureters, had sloughed away and the bladder was protruding. He said that not one of these cases, of which he had seen a great many, was due to the use of the forceps; but rather to not using them, and that they only could occur in places where, there being no intelligent medical man, a woman was left for several days or a week with the fœtal head impacted in the pelvis. The moral he drew from the case was, never to delay applying the forceps if the head does not recede after each pain, for he said that he had known even half an hours pressure to cause sloughing.

In answer to a question I asked him, about hysteriotomy for cancer, he replied he was not favorable, as the disease nearly always returns.

He was much opposed to the cautery, because it leaves behind it a very lowly organized structure (scar tissue), which falls a ready prey to the disease. Besides removing the cervix almost never removed the whole disease.

He then took over the instruments, and operated in a few minutes on a case of lacerated perineum. The case was peculiar in that there was no laceration, it having been nicely closed up by some other surgeon, and because he called it a case of rectocele, although the operation was his well known and improved laceration operation. A little further modification is that he passes his needles from above downward, so as to draw the perineum up, and he takes care not to put any stitches through the skin of the labia, all the stitches being inside the vulva, except one or two in the stem of the Y.

I went down to Philadelphia to see Goodell perform forcible dilation of the uterus, but was disappointed, he having done one the day previous, which was doing well, as they all do. He is careful to keep the speculum filled with sublimate solution while using his dilator. Strangely enough he was just doing the same operation on the perineum that Emmett did the day before, and gave the same reasons for it.

Dr. Osler is making a great name in Philadelphia as a teacher and consultant, being frequently called in by his elder colleagues in difficult cases. I must now close, but will write again from London.

Yours truly,

A. Lapthorn Smith.

LONDON LETTER.

Dear Record,—I had only time to write a few lines from New York, and I omitted to mention that Emmett, in answer to my enquiry as to what he thought of

Alexander's Operation.

replied that he did not believe in it, for the reason that the benefit resulting from it could not be lasting, and, moreover, that any good obtained by it could be reached better by other means. When in Liverpool I made a point of interviewing Dr. Alexander. He is a medium-sized rather young looking man, peculiarly unaffected in manner, appearing more like a Canadian in this respect as well as in accent. He was engaged in getting up his statistics for a paper to be read at the International Congress, although he will not be there himself, but received me very cordially, and arranged to have a case to operate on, when I returned to Liverpool in July. He said he was more in favor of the operation than ever, one of the last cases he performed having been complicated with inguinal hernia, for the radical cure of which, as much as for the displacement of the uterus, he operated. He thinks the cause of disappointment in the hands of other operators is that they do not pull the ligament out far enough, it generally requiring to be shortened as much as four or five inches. He is always anxious to include the peritoneum in his ligature for closing together the pillars of the ring, the material for his ligature being silkworm gut. This he leaves in for several months if it does not cause any irritation, but removes it sooner otherwise. He does not leave any deep sutures in, but brings them right through the skin, and ties them on the surface.

I made the acquaintance of several gynecologists in Liverpool, but none of them had ever done Alexander's operation, nor did they seem to believe in it.

I spent an afternoon with Dr. Warren of the Infirmary, and the leading gynecologist there, who performed an exploratory incision, and subsequently drainage for removal of a purulent collection in the abdomen, resulting from the breaking down of a cancerous uterus. Speaking of ovarian and tubal disease, he said dilatation of the tubes was a very common condition, and in support of his statement he proceeded to pass Simpson's sound through the tubes of half a dozen women, right into the peritoneal cavity. This potency of the Fallopian tubes made clear to me several rather puzzling cases, in which I had, in my practice, passed the sound a distance of six or seven inches, much to my horror, as I thought at the time that the patients must have been pregnant, but they were not. I had merely, without knowing it, passed the sound through the Fallopian tube. Dr. Warren was opposed to the so frequent removal of the ovaries as was practiced by Tait and others. He referred to the case of Dr. Trulach, one of the leading practitioners of Liverpool, who was dismissed from the Hospital for having spayed a number of young girls, somewhat on the general principle, apparently, that girls were happier without ovaries than with them.

In London I found Gynecology in such a diffused condition, that one could not spend one's time very profitably in studying it there. It is

stuck on generally to the large hospitals, in some of which even the gynecologists are not allowed to operate, but must hand over their cases to the surgeons for operation. In Guy's, however, they are thinking of giving the Gynecologist some beds of his own. From general practitioners in several parts of England, I was sorry to learn that the profession there was generally in a bad way. The licensing bodies are all quarrelling among themselves, and at the same time they are turning out such an immense number of doctors, that there is no possibility of a quarter of them gaining a living.

The more intelligent and better off of the lower classes are attended free at the hospitals; the paupers are attended by the parish doctor, who receives about one thousand dollars a year for making about fifty or sixty visits and consultations a day, including medicine, to do which he employs unqualified assistants at less wages than he pays his coachman; so that the only way a young medical man has left in which to earn his living is to attend the scum of the working classes, who are about the lowest of the low, at a rate of about three pence to six pence a visit, including medicine. If he won't do that he may be so fortunate as to get a position as doctor on a steamship, at from twenty to forty dollars a month, while the voyage lasts, and paying his own expenses when she returns to port and until she sails again. The only other career open to him is to go as assistant to a practitioner, where he generally receives the same pay, but not nearly so much consideration as the doctor's servant man.

We should take a lesson in Canada, while there is yet time, from this condition of the profession in Great Britain, and by raising the standard of entrance and *increasing the number of years of classical study* required, before being even allowed to try for the matriculation examination, prevent a crowd of young men from joining the ranks of the profession, for whom an honorable living is not to be had. We who permit them to enter our ranks are not altogether blameless if the struggle for existence compels them sometimes to resort to methods which bring disgrace on us, as well as on them.

It is quite easy for a butcher's boy, or a scavenger even, to get crammed sufficiently in a year or two to pass our present entrance examination, but he would not be able to produce a certificate of nine years' studies, including physics and philosophy. It is all right to manufacture medical men by the hundred for the United States, where there is a demand for such, but they should be stamped "For export," while the number of those who are to practice in Canada should be kept within the limit of the requirements of the country.

I am leaving in a few days for Paris, where I am going to place myself under the instruction of Dr. Apistole, who has attained a world-wide celebrity through his remarkable treatment of fibroid tumours of the uterus by means of electricity. I shall then write again, endeavoring to give your readers some idea of the wonderful progress electricity has made during the last few years, as a therapeutical agent.

Yours truly,

A. LAPTHORN SMITH.

LONDON, April, 1887.

CORRECTION.

Editor CANADA MEDICAL RECORD.

DEAR SIRS:—Since writing my last letter from the Hub I have had the pleasure of witnessing an ovariotomy by Dr. Homans of Boston at St. Margaret's Hospital. I have never seen an ovariotomy more quickly and skilfully performed, and with less display and pretence. The result has been excellent. I find that I have been misinformed as to Dr. Homans' views of Listerism. I stated that he did not believe in Listerism, and have wronged him greatly. He is a firm believer in the use of antiseptics; and if any septic germs float around it is not from the want of the spray and every aseptic precaution.

J. L. F.

BOSTON, April, 1887.

Progress of Science.

CHRONIC PURULENT OTORRHŒA, ITS NATURE AND TREATMENT.

Condensed from a paper read before the Philadelphia County Medical Society.

BY CHARLES H. BURNETT, A.M., M.D.,
Professor of Otology in the Philadelphia Polyclinic, etc.

A chronic purulent or muco-purulent discharge from the ear is usually the result of inflammation of the mucous membrane of the middle ear, and, as such, implies the existence of a perforation in the membrana tympani, through which the purulent matter escapes into the external auditory canal. The perforation in the membrana tympani is usually in that part of the membrane below a line drawn nearly horizontally through the short process of the hammer—*i. e.*, the so-called membrana vibrans. In some rare but very important cases, the perforation is in the flaccid membrane,

or the membrane of Shrapnell, which lies above the short process of the malleus.

Chronic otorrhœa is both common and important, is met by all practitioners of medicine, and demands, therefore, their careful attention, both on account of the annoyance its presence gives the patient, and the danger to hearing and life which lurks in its persistence in the middle ear.

Chronic purulent otorrhœa generally begins in childhood. The original cause of otorrhœa is chiefly naso-pharyngeal, and Eustachian tubal catarrh, induced by coryza, teething, and the acute exanthemata. Teething, by inducing a reflex irritation in the middle ear, leads practically to catarrhal inflammation of that cavity, perforation of the drum membrane, and the establishment of a chronic running. Purulent inflammation of the middle ear is almost invariably preceded by pain, and often constitutes the cause of earache in children.

Among the causes producing purulent otorrhœa in adults, must be named swimming and diving in cold water, plunging the head under cold water, washing the head and allowing it to dry in a draught of air, and also the use of cold water in the nasal douche, and the inhalation of various patent powders, snuffs, and fluid preparations advertised for the cure of nasal catarrh.

Tuberculosis of the lungs is also a cause of subacute and chronic purulent otorrhœa. This form is characterized by little or no pain, by its tendency to affect the posterior and upper parts of the drum membrane and cavity, and by its resentfulness of all forms of treatment but the mildest. It is supposed to be due to reflex inhibition of vasomotor power in the arterioles of the ear, supplied by the carotids. The irritation which thus acts reflexly is in the diseased lung. The irritation, passing by the pneumogastric to the sympathetic system in the neck, inhibits influence over the carotids. Passive dilatation ensues in this vascular tract, and those parts of the membrana tympani and middle ear supplied by it undergo passive congestion and inflammation of a low form, without much or any pain, the purulent matter ruptures the membrana, and an otorrhœa, chronic from the outset, is established.

The tendency to chronicity in all aural discharges is favored by the difficulty of keeping the ear clean, and by the improper treatment so often instituted. The exposure, too, of the mucous lining of the drum cavity to the atmosphere, by means of the perforation in the membrana, irritates the mucous membrane. and promotes further inflammation.

If chronic purulent discharge from the ear is associated with and kept up by chronic catarrh in the naso-pharynx and the nares, the rhinitis must receive due attention, or the discharge will not, without great difficulty, be checked.

The natural tendency of chronic purulent disease in the drum cavity is to impair the hearing.

After the destruction in the membrana, disorder in the ossicles, impairment of hearing, and the establishment of a chronic purulent otorrhœa, the disease may continue uneventfully on this plane for years.

These are the neglected cases tending to the development of granulations and polypi *upon the mucous membrane of the cavity of the drum.* As these form in the diseased ear, the discharge increases in quantity, and the hearing grows duller.

Inspection now reveals a polypus, or perhaps two, with distinct pedicles. Or, if these have not yet formed, granulations are seen, which more or less obscure a view of the drum membrane. Aural polypi vary in size, from a buckshot to a large marrowfat pea; or, if old, and sufficiently compressed by the auditory canal, they assume the shape of the latter, and finally extend from the meatus, after attaining a length of one and one-half to two inches.

Instead of the formation of polypi, the purulent disease may be more destructive, and produce death of the mucous-periosteal membrane in the drum cavity, and of the subjacent bone. The death of osseous tissue in the aural tract may take place in the tegmen tympani, just beneath the brain, or in the so-called antrum of the mastoid cells.

When the tendency of this disease has brought about necrosis in the regions named, the affection has assumed a most serious aspect, because a fatal issue may now be induced at any time by either an embolic process in the brain, the lungs, or the liver. Prior to this course, a fatal meningitis may be set up by an extension of the disease through the roof of the drum cavity, or through the fenestræ, and thus into the labyrinth and brain, or the necrotic disease having passed into the mastoid cells, the lateral or sigmoid sinus may be affected, and purulent phlebitis at this point aroused. A clot then may be formed in the sinus, pieces of which enter the circulation, and thus an embolic process established at some vital point.

In chronic otorrhœa, warnings of the unfavorable advance of the disease are given, by facial paralysis, violent ear pain, with fever and delirium, and inflammation within the mastoid cells.

Facial paralysis indicates an invasion at the upper and back part of the drum cavity, and meningitis may ensue. Inflammation of the mastoid cells is more likely to be followed by phlebitis of the lateral sinus and its consequences.

Cases of chronic otorrhœa with mastoid inflammation, and phlebitis of the lateral sinus, sometimes terminate fatally by embolism in the lung or liver, without any cerebral disease. Patients should be encouraged to have aural discharges stopped as soon as possible, whether acute or chronic. It is an injury to them to foster in their minds the idea that discharges will stop of themselves, or, if not, that they had better continue to run. Abnormal discharges from no other part of the body are allowed to run on disregarded, and, surely, discharges from the ear should not be, for they are as

amenable to proper treatment at those elsewhere, and if neglected, may become serious. From the deep and peculiar situation of the drum cavity, purulent discharges from this part of the head are likely to be retained, and to undergo decomposition. This favors continuation and extension of the disease, and the muco-periosteal nature of the tissue in which the affection has its seat renders death of the subjacent bone imminent, with consequent involvement of the cranial cavity. The patient, therefore, should demand of his physician an intelligent consideration of such a malady.

Treatment.—The first consideration in the treatment of chronic purulent otorrhœa is cleanliness and cleansing. Cleanliness is demanded in order to prevent decomposition of the discharge in the ear, and septic influences from such a nidus. Cleansing the ear is necessary to enable the surgeon to make a diagnosis of the condition of the fundus and the membrana, and in order to prepare the ear for treatment.

Cleansing the ear is best accomplished by the surgeon, and should very rarely, if ever, be entrusted to the patient. It is best effected by syringing with tepid water, either with or without a disinfectant, if the discharge is copious and tenacious. If, however, the discharge is neither copious nor thick, the ear can be cleansed by a small dossil of absorbent cotton on the cotton-holder. Failure in this procedure is often attributable to the use of too thick a pledget of cotton. This should not be more than five centimetres in diameter. If it is larger it gets wedged in the meatus or in the canal, the fundus is not reached, or only with difficulty, and after pushing, which is painful to the patient, abrasion of the canal, or even of the deeper parts of the fundus and the membrana, may ensue.

The syringe may be employed without illuminating the ear by the forehead mirror, but the proper and successful employment of cotton on the cotton-holder can be done only under the forehead mirror.

In infants and very young children, with very narrow meatuses, cleansing is most conveniently done by syringing with warm water, the return current from the ear being caught in a towel held beneath the auricle. After syringing, the water must be carefully mopped out of the fundus of the canal by absorbent cotton, in order to gain a view of the diseased parts, otherwise the refraction of the water will give a very distorted view of the objects seen through it.

Cleansing the middle ear is furthered by using some form of inflation of the tympanum.

After the first cleansing of the external auditory canal and its fundus, the surgeon should find out whether the perforation is above the so-called folds of the membrana flaccida or below the folds, in the membrana vibrans. Sometimes a perforation exists in both these portions of the membrana tympani at the same time; but this is not common. It is highly important to determine in which of these parts of the drum membrane the perforation lies, since the treatment must be modified by the position of the perforation.

Let us first consider those cases in which the perforation is large and in the lower part of the membrana, the membrana vibrans. These are the most frequent.

Earache from acute inflammation in the tympanic cavity, in such chronic cases of purulent otorrhœa, must be combated by gentle warm-water syringing or irrigation, and in protecting the inflamed mucous membrane with insufflation of powdered boric acid. These insufflations and all others can be done either with the blow-tube, on the principle of the blow-pipe, or by the hand powder-blower.

In those cases of acute inflammation in chronic otorrhœa, with large perforations in the membrana, the pain can often be allayed by the use of instillations of cocaine, because the perforation in the membrana permits the entrance of the solution into the drum cavity, and its ready contact with the mucous membrane.

Cocaine solutions instilled into an ear with imperforate membrana tympani are important to quell pain in the ear. They also seem valueless even when the membrana contains a small perforation, because they still seem to fail to reach the inflamed mucous surface.

If coryza is present, as it is apt to be in these acute attacks in chronic otorrhœas, it, of course, must not be disregarded. The prognosis in these cases is favorable as to restoration to a relatively normal or healthy state, if the subject is in ordinary health.

It is in these cases of purulent otorrhœa with large perforations in the membrana tympani, that preference should be given to the so-called dry treatment. In this form of treatment very little water is used for cleansing, and only when the discharge is thick and copious, and hence not easily removed by absorbent cotton. The reason for this preference of dry treatment is that the use of water favors the continuance of the discharge in many cases, and promotes a tendency to the formation of granulations and polypi. If syringing the ear is to be done, it must be carried out by the surgeon, and not entrusted to the patient. After the ear is cleansed by either of these methods, some form of boric acid, finely powdered, should be employed by insufflation. This enters the tympanic cavity, and hence comes in direct contact with the inflamed mucous membrane. It remains there more readily than fluid preparations, and hence acts longer. The beneficial effects are due to the antiseptic properties of the boric acid, and to the protection the layer of powder gives to the mucous membrane.

If this dry treatment does not give entire satisfaction, as it may not or will not if granulations or ulcerations exist beyond the reach of the powder thus blown in, resort may be had to instillations of astringent and astiseptic solutions, as silver nitrate

—not less than forty grains to the fluid ounce of water; or carbolic acid solutions from three per cent. to five per cent. in strength. These are to be put in the ear after it is cleansed, and followed by a dressing of insufflated boric acid, either in simple or in compound powder.

In cases of chronic purulent discharge from the attic of the tympanic cavity, with perforation only in the membrana flaccida, the dry treatment cannot be relied upon, because of the smallness of such perforations, and the consequent inability of the surgeon to blow the powder into the diseased cavity. In these cases the treatment consists in the application of solutions to the attic, through the perforation, by means of the tympanic syringe. The long slender nozzle, six centimetres long by one millimetre in diameter, must be conveyed under illumination by the forehead mirror down the auditory canal to the seat of disease. I have found the best results to follow the use of injections of a three per cent. so ution of carbolic acid by this means, into the attic cavity of the tympanum after thorough cleansing of the attic by injections of hydrogen dioxide, which thoroughly removes all pus. They do not tolerate nitrate of silver. It is well to follow these applications by insufflations of boric acid into the fundus of the auditory canal. For, though they cannot reach the attic unless the perforation be large, they have an antiseptic effect about the perforation and the rest of outer surface of the membrana tympani and the fundus of the canal.

Cases of chronic purulent disease in the attic are difficult to treat, on account of the bad drainage from those parts above the ossicles,and because of the small perforation usually found in the membrana flaccida. They are also dangerous to the life of the patient, because the disease lies near the tegmen tympani, directly beneath the brain. Natural deficiencies in the bone at this point exist so frequently that the meninges and the mucous membrane of the roof of the drum cavity are often in apposition.

In order to facilitate better drainage of purulent secretions from the attic in chronic disease, and more efficient medication, especially by the insufflation of powders, Dr. Sexton has suggested, and frequently performed, when the membrana is largely destroyed, an operation for its removal, and then that of the malleus and incus, or their remnants. The fundus is then treated with a powder of salicylic acid and boric acid, until a dermoid cicatrization ensues. This operation is applicable to chronic attic disease, *without perforation of the membrana flaccida*, but with large destruction of the membrana vibrans, in which the diseased malleus and incus interfere with drainage of the attic, downward in to the atrium.

In any case of chronic purulent otorrhœa, so long as we can detect no lesion beyond impaired vibration in the ossicles, with defective hearing, as a consequence of the chronic disease in the mucous membrane, the cure of the affection may be considered as probable, excepting in tubercular cases far advanced in pulmonary disease. By curing the purulent disease of the mucous membrane, the growth of granulations and polypi, and the occurrence of necrosis and caries of the adjacent bone, are prevented.

If, however, the ear has not been treated, or improperly treated, granulations and polypi may be found, with impairment of the hearing. The granulations are best removed by touching them, and only them, with chromic acid, carefully conveyed to their surfaces on a small cotton tuft, not more than two millimetres in diameter, on the cotton holder, under perfect illumination of the canal and fundus by the forehead mirror.

If polypi, with distinct pedicles, have grown from the mucous surface of the middle ear, and extend into or from the perforation in the membrane, they must be extracted with the polypus snare, and their pedicles touched every day or two, until they disappear. These are entirely curable, and the discharge from the ear usually ceases after the removal of the polypus and the destruction of its roots, and the hearing improves. The removal of the polypus, without subsequent treatment and destruction of its pedicle, is useless.

Instead of this conservative, hypertrophic action on the part of the mucous membrane, in may slough, leaving a subjacent bone bare. The latter then dies, either superficially or in its profounder parts, and some of the evils I have sketched are experienced by the patient. In some cases of profound inflammation and ulceration of the mucous membrane of the drum cavity, denuded bone can be felt with a probe, and crumbs of bone are thrown off with the aural discharge. But with the improvement in the condition of the ear, these particles of dead bone cease to appear, and denuded bone can no longer be felt. In such cases the ear should be syringed once daily, by the surgeon, with tepid water, in which salt or potassium permanganate may be placed. Or the ear may be syringed with weak solution of corrosive sublimate, 1 : 1000, carbolic acid five per cent., or with undiluted hydrogen dioxide (Lehn & Fink's, or Schieffleins). This drug has the great advantage in breaking up and removing all pus, and of informing the surgeon when this is accomplished, by the cessation of foaming, which ensues as soon as there is no more pus, with which it makes the frothy reaction. Thereafter, the ear is to be dressed with the powder of boric acid already named. Cleanliness and antiseptics, with attention to the general condition, form the guiding motives in the treatment.

If sequestra form, they should be removed, if possible.

In many cases, indeed, I am inclined to say in most cases, of necrosis of the temporal bone from chronic aural purulency, operative interference is well-nigh useless. Unless it be the mastoid cortex, all other parts of the auro-temporal surface are extremely difficult to operate upon, and surgical

interference becomes a dangerous undertaking. Again, when the surgeon is consulted in cases of intracranial disease, or systemic septicæmia, arising from chronic purulent disease and necrosis in or about the ear, the patient is beyond aid. To trephine for cerebral abscess, which has resulted from chronic aural disease, is to operate on a moribund patient, and to hasten surely the fatal issue. The time to aid such a sufferer was when the chronic purulent otorrhœa could have been checked, and before it had induced necrosis of bone, or embolism. In my opinion, there never is a moment, after the cerebral abscess is formed, that an operation for its relief is justifiable, excepting, perhaps, in those instances in which a sinus can be found leading to it from the mastoid or squama. In regard to mastoid trephining, for so-called mastoiditis and periphlebitis of the lateral sinus, my opinion is much the same.

A chronic purulency in the tympanic cavity may gradually and painlessly affect the mastoid antrum, its cells, and its outer cortical as well as its inner wall, the latter being the outer wall of the lateral sinus. This diseased state in the furrow of the lateral sinus is of the most serious import, but an operation on the mastoid cortex cannot arrest its progress or remedy its effects. Too often, when pain in the region of the mastoid is felt, and other well-known symptoms of so-called mastoiditis arise, the pain is really due to inflammation in the lateral sinus, or deeper parts from such chronic d sease in the bone, and not to matter pent up in the mastoid cells, which a perforation in the mastoid can relieve. I am forced to such conclus ons, b:cause fluid matter from the drum cavity and mastoid antrum can escape, in most cases, from the external ear. Also, because in many cases of pain in and about the mastoid, with symptoms which are supposed to justify trephining its outer cortex, the cavity has not been found filled with fluid matter seeking an escape, but with some inspissated pus at most; while periphlebitis in the lateral sinus has been discovered, having its origin from the neglected tympanic disease, which trephining is powerless to cure.

Even if the mastoid cortex and cavity are found diseased, an operation upon them will do no good if the lateral sinus is diseased, and perhaps the seat of a clot.

In many cases of tumefaction behind the ear, in painful acute inflammation in chronic cases, Wilde's incision does give great relief. And in some such cases where this incision has been followed by perforation of the bone, relief and apparent cure have followed, it has been because there was no disease in the inner mastoid wall and the lateral sinus. In such cases the local depletion gave the relief, and mastoid perforation was purely gratuitous. Hence, in acute cases of otitis media, great care should be taken not to resort precipitately to mastoid trepanation. In chronic cases it is of value in very few instances, and the indications for its employment are not well defined. In many cases the mastoid becomes œdematous, brawny, shining, sensitive to both deep and superficial pressure, and painful to the patient. These are often relieved by poulticing and leeching, without even Wildels incision. Sometimes, if let alone, they undergo speedy resolution. If the lateral sinus has not been invaded, there is no need of haste. If has been attacked, mastoid trephining will certainly not check it.

It must not be forgotten that many instances of pain and swelling about the mastoid are due to congestion and swelling in its mucous lining, and in that of the middle ear and mastoid antrum. The circulation both within and without the mastoid is then impeded, and swelling, œdema, and tenderness of its outer surface are the result. Hence the relief obtained sometimes by spontaneous resolution, or by artificial depletion over the cortex of the mastoid.—*Phil. Polyclinic.*

TREATMENT OF PNEUMONIA IN THE NEW YORK HOSPITALS.

Bellevue Hospital.

Immediately upon admission every patient under the charge of Prof. Alfred L. Loomis undergoes an examination for the determination of the following points:

1. The extent and location of pulmonary consolidation and amount of complicating pleurisy.
2. The temperature and condition of the heart as indicated by its rhythm, force, and amount of muscular element in the first sound.
3. The condition of the kidneys.

When the patient is admitted during the initial shock, full doses of morphia are administered hypodermically, and repeated with sufficient frequency to relieve pain, during the first three or four days, or until the consolidation is complete.

Every patient is placed in bed, clothed in an oil-silk, flannel-lined jacket, which is made to come close up around the neck and to extend well down on to the trunk, and is put upon a diet of milk, vichy, chicken soup, and beef-tea, the selection of food being somewhat affected by the limits of hospital dietary. This much is routine.

When consolidation is confined to a lower lobe, the cough, expectoration, and pain moderate, the temperature below 104° F., while the pulse is regular with a strong first sound of the heart, and the urine is normal, nothing further is done beyond keeping the bowels freely open by some mild cathartic, as pulv. glyc. co.

The general treatment is then purely expectant. The temperature and pulse, however, are taken every four hours and the urine examined daily.

When the temperature reaches 104° F., or more, fifteen to twenty grains of quinine are given

at a single dose. If at the end of six hours no reduction of temperature is produced, twenty grains are given in divided doses within an hour. As the drug used is "hospital quinine," these doses are possibly slightly larger than would be required in general practice. When they fail to reduce temperature equal parts of quinine and antipyrin are employed, but always in combination with some form of cardiac stimulant, as alcohol or caffeine. If the temperature is not affected by the second dose its use is not continued.

Indication for stimulants are found principally in the cardiac condition. Patients with consolidation at the apex, however, and alcoholic subjects are put upon stimulants from the first.

The cardiac stimulants used are alcohol, caffeine, digitalis, and ammonia, the first two being given with about equal frequency and for prolonged effect, while the others are used more for emergencies in the latter stages.

An irregular, uneven, intermittent pulse, or weak or absent first sound are indications for stimulants to be given p. r. n.

It is seldom found necessary to employ measures directed especially to the cough. When this is distressing, with little expectoration in the earlier stages, opium is employed to mitigate its severity but not to check it entirely; later in the stage of resolution opium is avoided and carbonate of ammonia given in connection with infusion of serpentaria or wild cherry.

Pain is controlled early by opium and *large hot* poultices, later by poultices alone, if possible.

The earliest indications of renal complications are met by the ethers, infusion of digitalis, and nitroglycerine.

Sleeplessness is relieved by bromide and chloral (alone in robust patients), and with the addition of cardiac stimulants in alcoholic subjects.

Œdema is treated by dry cups freely applied over the entire chest, atropia hypodermatically, whiskey and digitalis internally, and the free inhalation of oxygen.

St. Luke's Hospital.

The treatment of pneumonia in Dr. Kinnicutt's wards in St. Luke's Hospital, during the past five years, has been wholly an expectant one. Absolute rest in bed in a *strictly* horizontal position, not only until defervescence occurs, but for several subsequent days, is a rule which is carefully observed in his service. The patients are rarely permitted to assume a sitting posture, even for the purpose of an examination. Several instances of sudden death from heart failure, in the period immediatety following defervescence, on the patient attempting to rise, have convinced him of the wisdom of a routine rule of this kind. Light flaxseed poultices or a layer of cotton-wool covered with oiled silk, applied over the affected area, have been found serviceable in promoting the comfort of the patient.

During the developing stage of the pneumonic process (the first three or four days), opium in small doses (morphine one-sixteenth to one-eighth grain given by the mouth or hypodermatically, two or three time in twenty-four hours) has proved of great service in controlling the symptoms of nervous shock which so frequently obtain at this stage of the disease, and in affording relief to the suffering of the patient. It has also seemed to combat, in a measure, the tendency to heart failure.

The employment of alcohol has been governed by the symptoms in individual cases. With the first indication of cardiac weakness, it has been the rule to institute its use in small doses and to watch carefully its effect. The pulse, the tongue, and the mental condition are accepted as guides for its continued use and for the amount to be given. Many cases have convalesced satisfactorily without its employment at any stage of the disease; again, twelve or more ounces of brandy have been given in the twenty-four hours, with marked benefit and recovery. Its use in diminished doses during the first days of convalescence has often been found advisable.

Caffeine and digitalis have been used very uniformly as heart tonics, and Dr. Kinnicutt believes with benefit. During the past several months, strophanthus, in the form of the tincture (five drops, three or four times in the twenty-four hours), has been employed with excellent results. He now prefers it to all other cardiac tonics in this disease. Antipyretics have seldom been employed.

On the temperature reaching 105°, a single small dose of antipyrine, eight to twelve grains by the rectum, has been given and repeated if necessary.

Aside from his disbelief in the necessity of the general use of antipyretics in pneumonia, Dr. Kinnicutt is convinced of the intolerance of large doses of the group of carbon compounds in this disease.

Finally, the alimentation of the patient has received very careful attention; the food has consisted of milk, in its raw state, or peptonized. The hospital records show the following satisfactory results under the above method of treatment.

Forty cases of acute labor pneumonia were treated in the wards from December 1, 1884, to, December 1, 1886. There were six deaths, 15 per cent. (excluding one which fairly should be disregarded, death occurring twelve hours after admission to hospital on the fifth day of the disease), all in complicated cases; the complication being: (1) amyloid spleen, liver, and acute nephritis; (2) chronic nephritis; the disease), all in complicated cases; the (3) endocardial aneurism, mitral stenosis, chronic nephritis; (4) alcoholism; (5) urethral stricture with retention of urine; (6) uræmia and chronic nephritis. Serious complications existed in ten of

the cases which recovered. Double pneumonia was present in three of these.

If the nature of the symptoms points strongly toward the development of pneumonia, although it is not yet perfectly evident, Dr. Beverley Robinson avoids the use of arterial sedatives like aconite, and prefers to order a few doses of ammonia, a small amount of opium (Dover's powder preferably), and a flaxseed poultice over the affected side. When the pneumonia can be clearly recognized by physical exploration of the lungs, moderate doses of digitalis (fl. extr. ℥j), and from two to four ounces of brandy or whiskey in the twenty-four hours, are prescribed.

A sufficient quantity of milk given regularly every hour, with an egg-nog, or beef extract, morning and evening, is allowed. Flaxseed poultices, containing a small proportion of mustard, are continued as a local application, and are renewed once every three hours. To retain their heat and moisture, they are covered externally with gutta-percha tissue or oiled silk.

If the bowels are constipated at the beginning of the attack, or subsequently, a dose of calomel is ordered (5 grs.), followed in a few hours by a saline aperient (℥ ss–℥ J of Epsom salts). Whenever the patient is much prostrated, and the bowels remain torpid, a laxative enema is preferred. In cases where the bodily temperature rises above 103° Fah. in the axilla, five to ten grains of the phosphate of quinine by the mouth, every four hours, during the continuance of the period of active hyperpyrexia, are ordered. Whenever the heart shows symptoms of failure, either by extreme frequency, weakness, or irregularity of its beats, the amount of brandy or whiskey to be given is rapidly increased, and strong, black coffee is also ordered.

In a very grave case of double pneumonia treated during the past winter, and in which a cure followed, the disease was combated during the acute stage almost entirely with brandy and black coffee, a half ounce of one or the other being given alternately every half hour. (The brandy should be old and pure.) Later, dry champagne was substituted for the brandy.

Some years ago, Kerms mineral (oxsulphuret of antimony), in a vehicle of syrup of gum with water, was frequently ordered by Dr. Robinson every two or three hours, in order to promote expectoration. Although excellent results were obtained from the use of this drug, for no sufficient reasons it was abandoned, and never since resumed.

It the heart action remains feeble during the stage of resolution, although the fever has disappeared during several days, he has found convallaria majalis an excellent substitute for digitalis. It agrees with the stomach better than the latter drug, and often acts quite as well as a heart tonic.

In the convalescent period, when the lung remains impervious to air during a considerable time, he has found repeated fly-blisters over the affected side extremely beneficial in clearing up the local intra-pulmonary condition. At the same time that blisters are applied he orders small doses of belladonna, strychnine, and carbonate of ammonium in infusion of cinchona, repeated several times daily, so as to strengthen the heart's action, and tone up the general system. Whenever delirium is present, it is allayed with ice-bag to the head, or by the internal use of ether (in perles), or of the bromides. Venesection for the asphyxia accompanying a dilated and over-burdened right heart, is occasionally advisable, and when performed under favorable circumstances, has been found useful. In his experience, however, the evident indications for this little operation have rarely occurred. The main source of danger in pneumonia, as a rule, seems to pertain to rapid or sudden heart failure. This accident may be prevented in many instances by the internal administration of repeated and considerable doses of black coffee and alcoholic stimulants.—*N. Y. Medical Record.*

THE TREATMENT OF PNEUMONIA IN THE PHILADELPHIA HOSPITALS.

Hospital of the University of Pennsylvania.

Dr. Pepper reduces the initial high fever in cases of pneumonia in his wards (if, as unfortunatlye rarely happerns, the case has been admitted just after the onset) by antipyrin or by the external use of cold water. It was for this, accompanied with severe pain, that venesection was formerly used; and he still advises its use at this earliest stage if high fever returns promptly after reduction by the above remedies. They will often produce a favorable impression, however, with less risk. Throughout the disease the fever must be carefully watched and often requires to be promptly reduced. Sometimes large doses of quinia—as thirty or forty grains given in two doses at intervals of four hours—will do this; but antipyrin is so much more prompt and certain that he prefers using one of them, and especially antipyrin, for the occasional control of the hyperpyrexia, while giving continuously a moderate amount of quinia, say ten or twelve grains daily. Quinia meets several indications in pneumonia, and he nearly always gives it, adapting the dose to the grade of disease and special conditions of the patient. As the stomach must be very carefully guarded in pneumonia and everything avoided that might irritate it, it is often better to give quinia by the rectum.

He is more in the habit of using aconite than veratrum, but one or the other of these powerful and reliaflle arterial sedatives should be used during the early days of the attack, given in frequent and moderate doses so as to produce safely their physiological effect by lowering the pulse rate, relaxing the system and aiding in reduction

of fever. Later, if the pulse loses force or after the area of the disease has become defined, the indication for arterial sedatives has usually passed.

Not only must care be taken to avoid irritation of the stomach, but in many cases, especially in the early stage there is much gastro-hepatic congestion and irritation present, and here it is important to limit ourselves to relieving this by short courses of small doses of calomel with or without soda, using meanwhile quinia by the rectum to control fever. It is especially in these cases that aconite is preferable to veratrum on account of its tendency to irritate the stomach. After the disease is developed, ammonium carbonate is preferred to stimulate respiration and favor resolution. It is usually given in simple emulsion, and in doses of five grains every two or three hours for an adult.

The diet must be adapted carefully to the state of the stomach. It should be liguid throughout and for the first two or three days should be restricted, but after that may be more free and concentrated if well received. It is extremely important that the patient be not allowed to make any exertion. Regid rest must, indeed, be insisted upon, for pneumonia is one of the diseases in which sudden death is apt to occur from any improper effort, as even of rising to sit upon a commode by the bedside.

The indications for alcoholic stimulants are drawn from the state of the circulation and nervous system. Many cases do well without any stimulus from the beginning to end; but on the other hand the signs of cardiac failure or of failure of nervous force call for alcohol, which may be required to be given freely. Of course, it is to be adapted, as to amount and mode of administration, to the state of the stomach. In general, a layer of cotton or wool batting stitched inside of the merino undershirt, over the outside of which a layer of oiled silk is placed, is preferable to poultices. The latter must be made skilfully to be pleasant; they must be changed frequently, and unless this changing is done with great care, there are both fatigue and risk involved. Of course, the above remarks apply solely to croupous pneumonia.

Dr. Osler, in hospital practice, recognizes two groups of pneumonic patients—the alcoholic and the temperate. A majority of the former die in spite of all treatment; a majority of the latter get well with any or with no treatment. That the mortality from pneumonia in the large general hospitals uniformly above twenty-five per cent. is due to the fact that to them are admitted the debilitated paupers of the community, with systems undermined by exposere and drink, and in no state to combat an acute disease. Alcoholics with renal inadequacy rarely survive pneumonia.

When the disease is limited, the fever moderate and the pulse good, a dilute acid mixture es given with Dover's powder to allay the pain and the cough. Cotton wadding or, if the patient prefer, light poultices are applied to the affected side. Blisters are never used.

At the disease can neither be cut short nor essentially modified by any remedies we at present possess, in severe cases we have to watch and meet the tendencies to death.

First. Heart failure from engorgement of the right chambers, and the lesser circulation, indicated by cyanosis and urgent dyspnea. Free venesection can alone meet this danger, and should be performed on the first signs of cyanosis, with failing heart. Good results have followed the removal of from eighteen to twenty-five ounces of blood. It is often left too late, and to be efficacious should be dnne early. It is not always successful. Two cases bled this season died.

Second. The fever, against which quinine, antipyrin, and antefebrin are employed; but the action of antipyretics in pneumonia is more uncertain than in other acute fevers. Cold sponging and the cold pack are more effectual when the temperature becomes dangerously high.

Third. The increasing debility. systemic as well as cardiac, demands stimulation and careful feeding. A majority of the fatal cases die of progressive heart failure, against which alcohol is given freely. Digitalis is also employed, but the full tonic action of this medicine is rarely seen in the weak heart of fever. Camphor and strychnine are useful in this condition.

Of medicines, carbonate of ammonium is freely given. Opium is used to allay the early pain and to quiet the cough. Extensive bronchitis with liquid expectoration is a contraindication. Arterial sodatives are not much employed, but when the cases are seen early, aconite is sometimes given. In the mild cases they are not often needed, while in the more severe ones they may be positively injurious. Expectorants are rarely called for, and when used the ammonia and nux vomica fulfill the indications. A milk diet is given, varied as occasion arises.—*Phil. Med. News.*

INTUBATION OF THE LARYNX FOR OBSTRUCTIONS ARISING FROM INFLAMMATORY CONDITIONS.

Our readers are all, to some extent, familiar with the new device invented by Dr. Joseph O'Dwyer, of New-York, of introducing a metallic tube into the larynx and leaving it there to be self-sustaining any length of time necessary for the obstructive condition to subside.

Failures in tracheotomy led Dr. O'Dwyer to make a study of the possibility of introducing a tube in extreme cases, instead of opening the trachea below the seat of obstruction. Having a position in the N. Y. Foundling Hospital, which contains a large number of children, and affords frequent opportunity for examining the anatomy of

the larynx, and (after some progress in the construction of a tube for trying it in the living patient) he gradually worked out a practical instrument.

Five years ago, Dr. McEwen, of Glasgow, Scotland, was working upon a rubber tube to take the place of tracheotomy, but in his endeavor, the tube was not self-sustaining in the larynx, and would not permit the epiglottis to close down. A quarter of a century ago. M. Bouchut, of Paris, made a tube of metal which was employed in seven cases, but they all died. The Paris Academy of Medecine, under the lead of Trousseau, condemned the use of the tube and Bouchut, discouraged, discontinued his endeavors to perfect the instrument, and it went out of notice and out of memory until revived in connection with the discussion of O'Dwyer's tubes.

As at present put up by the instrument makers, there are five tubes, adapted to different ages from one year to twelve years of age. Larger tubes must be made to special order. There is in the case, a gag of new construction, an instrument for introducing the tube, and another for its extraction.

The manipulations are said to be easy and quick after practice, but difficult in unpractised hands. Dr. Jennings, of Detroit, is reported (in the *N. Y. Medical Record* for Nov. 11th, 1886, p. 645) to have failed altogether to get the tube into the larynx. It is doubtless a question of practice and manual skill. The successes reported are far in advance of anything ever experienced in tracheotomy. There are two obvious reasons for this. The first is that the parents of sick children will consent to the measure as soon as there are alarming symptoms; and the second is that the shock of a surgical operation is avoided. The age of the patient and his exhaustion, through long suffering and insufficient oxidation of the blood, render him especially susceptible to surgical shock.

The use of the instrument is being rapidly introduced; Dr. Waxham, of Chicago, having become early enthusiastic over his success, as published in the *Chicago Medical Journal and Examiner* and Dr. Cheatham, of Louisville, as published in the *American Practitioner and News* for Nov. 13, 1886 has also become enthusiastic in praise of the instrument.

Dr. David Prince, of Jacksonville, Illinois, sends us, and permits us to quote two successful cases of intubation occurring in his practice.

The first, on November 25th, *ult.*, in a three-year-old boy, a patient of Dr. Malone, suffering from diphteria for several days, the patch of vegetation being visible on the palate and in the pharynx. The difficulty of breathing had become alarming, but manipulation (under ether) dislodged a large quantity of exudation, improving the respiration. The final introduction of the tube rendered the respiration easy. In a short time the tube was coughed out and held from being swallowed by the string which had not been detached. No further alarming dyspnœa occurred, and the tube was not returned. Under the use of calomel in minute doses, quinine and alkaline vaporization, the child made a slow recovery, though the diphtheritic vegetation continued several days. The lungs escaped invasion. The case was on December 9th; one of membranous croup, there being no diphtheritic vegetation in sight.

A seven-year-old boy, a patient of Dr. Halsted, exhibited a gradually increasing dyspnœa, until breathing was labored and the vermilion border of the lips dusky. The introduction of the tube (under chloroform) afforded complete and permanent relief. The tube remained in place one hundred and six hours and at the expiration of this time it was removed (under chloroform) without return of dyspnœa.

The child could whisper. and could swallow both liquids and solids while the tube remained in the larynx

Dr. Prince thinks that operators who have not become skilled through practice, should always make the attempt to intubate with the patient in a state of anæsthesia. Fright is avoided in this way; all struggling and consequent alarm of the patient's friends are also avoided. The operator himself is likely to be more deliberate, and to have less to distract him than with the child in the waking state.

Dr. Prince counts his tracheotomies for inflammatory obstructions by the number of his thumbs and fingers, and his failures in the same way. Some of the cases have died of shock, some have been relieved for a day, but all died within four days from the time of the operation.

It is generally conceded that in those cases in which the small bronchial tubes and the alveoli become invaded, death is inevitable. In these cases, intubation, relieving the laryngeal dyspnœa will produce temporary relief and prolong life, but the subsequent invasion of the lungs will produce a secondary pulmonary dyspnœa beyond the reach of any remedy. The case is the same with tracheotomy.

Among the references to the literature of the subject are the following:

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M. Bouchut, 1858. A paper read before the Paris Academy of Medicine.

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Feb. 1887

PRECOCIOUS CHILDREN.

SOME HINTS ON THEIR TRAINING AND EDUCATION.

The care and training of a precocious child are among the most vital duties that fall to parental oversight. It might be said that undue precocity in a child is a misfortune, not only to the parents, but more especially to the child, whose very brilliancy is often a cause for keen suffering. What is a precocious child? We should say that he is one whose mental activities are prematurely developed, whose nervous susceptibilities are so sensitive, that the slightest mental excitement finds expression in language that surprises us, whose sayings and doings leap far ahead of the average child, and whose conclusions are reached without the ordinary exercise of mental strain or systematic application.

The precocious child is constantly saying things so epigrammatic and brilliant as to call out the wonder of admiring parents and relations; and oftentimes these strange unnatural utterances are made the subject of remark in the presence of the child, and some newpapers often devote a column to this bright and abnormal child-talk. Nothing could be more harmful than such encouragement of a condition that is out of all harmony with healthful mental and physical growth.

As a rule, the precocious child is of a strumous or scrofulous diathesis, with a fair, brilliant complexion, blue eyes, and golden hair, beautiful to look upon according to popular standards. He is delicately sensitive to mental impressions, and alive to the conversation of persons much older than he. He generally goes on in his unique career, outstripping his brothers and sisters, as well as his schoolmates, in the committing of tasks at school, as well as in the reading of books far beyond their comprehension.

This generally goes on until the age of puberty, when he begins to falter. The hectic flush is seen upon the fair cheek, the eye becomes more brilliant, and the finer and the spiritual elements come out with almost supernatural intensity. By and by a slight cough arrests the attention; and, before the fond parent is aware, phthisis tuberculosis has laid the foundation for premature death.

Now, what shall be done to save such children, and make them develop into healthy men and women?

First, we would say, *Let them severely alone.* By this we mean, do not encourage the precocious development by pushing the child ahead, and showing the foolish weakness of exhibiting the child to visitors, or displaying him at the performances of Sunday-school concerts or public-school exhibitions. We always pity the poor victims of such scenes, who come before audiences, and recite standard poems or sing *cavatinas*, to astonished crowds in heated rooms, amid the glare of gas-lights, and dressed in tawdry finery, irrespective of the climate or weather.

We say we pity such children; and, when we look upon their pale faces and attenuated legs, we wish we had the power to send them home and put them to bed.

Second, be simple with such children; keep them young, and encourage them to talk child-talk, to read child-books, and to play with other children. Do not let them remain in the house in company with the older folk, when the bright sun is shining, and the other children are romping upon the green with all the glorious freedom of childhood.

We recall the case of a little boy who, at eight years of age, would crawl behind the sofa or under the table, and read *Paradise Lost* and the Waverley novels. The fond mother told of the incident with maternal pride. Alas! the dear boy was under the sod at twelve. The precocious child, whose brain is in a state of "super-excitation," must not be subjected to the discipline of the public school. Such children do not work well in a system so full of curbs and checks, so beset with "marking," and with rewards and punishments. The conscience of these children is usually morbidly acute, and the suffering occasioned by the exactions of marking and other tests for promotion is often painfully injurious. A private instructor or a select school, where there can be more elasticity in the working of the machinery, and where the child can be dealt with as an individual, is far better.

Of paramount importance is the physical training of the precocious child. From the very nature of the case, all undue excitement must be avoided. The full quota of sleep must be insisted upon. No late hours should be allowed, full of the amusements that are such a strain upon the nervous system. We have heard of a little precocious miss of eight summers, who, besides attending the public school, "takes lessons" upon the piano, goes to a dancing school, gives and attends children's parties, and who very often is not in her bed until ten o'clock at night. What a foundation for that child's future is being laid! The diet should be of the simplest character, consisting of food containing all the elements of nutrition, like milk, bread, and soups. Confections, condiments, and fancy dishes should never be set before children. Give fresh air in abundance, and insure the child to go out of doors in all kinds of weather.

By following the general plan which has been outlined, we think the precocious child can be carried safely over the critical line that marks the beginning of manhood and womanhood, and secure a healthful development that will serve a long lifetime.

We have not time here to touch upon the form of precocity found in the gamins of our great cities. This class of humanity is an enigma to the philanthropist and the maturity and adroitness of the wickedness attained by the newsboys, the bootblacks, and the vagabonds, are indeed a study. Our suggestions have reference to the precocious child as found in good families, and under favoring circumstances.—*Popular Science News.*

CONGENITAL HEREDITARY ATONIC DYSPEPSIA.

During a practice of twenty years, I have prescribed Lactopeptine to patients of all ages, and have never been disappointed in its action when indicated. But I desire to speak in particular of its action in a case of congenital hereditary atonic dyspepsia in an infant, to whom I began to administer this remedy on the third day after birth. Mrs. H. L. S., Langside, Miss., was delivered of a male child, in whom there were manifested well marked symptoms of atonic dyspepsia. The mother had been a victim of dyspepsia from girlhood, and had inherited the malady from her mother.

The infant was put to the breast a few hours after birth, and nursed readily; but almost immediately rejected the milk. Repeated trials all resulted in vomiting, followed by exhaustion. Other articles of food were tried, including cow's milk, etc., without improvement. The child was in great danger of starvation. On the third day, I began the administration of Lactopeptine. The effect was immediate and almost miraculous. I ordered one-sixteenth of the adult dose to be dissolved in about two ounces of breast milk (drawn from a robust, healthy wet-nurse) and administered every two and a half hours. There was no more rejection of milk—except the usual vomiting of curdled milk, to relieve the crowded state of the stomach, which occurred occasionally, after the first ten days. Condensed milk cow's milk (properly diluted and sweetened), Mellin's food, boiled bread (pap), were, after a while, substituted for breast milk, but always with Lactopeptine. A steady improvement was manifest from the beginning, and kept up during the first dentition, which process was gone through with in a most satisfactory manner. No untoward diarrhœa or intestinal disturbance characterize this period, and, at ten months, the child was virtually cured of its dyspepsia, and could eat and digest ordinary food, such as children of that age may do in good health.

The parents of the child believe firmly (as I do) that Lactopeptine saved their infant. In cholera infantum, in diarrhœa, and in all of the disturbances of the alimentary canal, during dentition and early infant life, I find Lactopeptine an ever-effective and reliable remedy. In adult dyspepsia all are now familiar with its beneficial effects; but I should be glad if the profession would be induced to try it in the vomitings, diarrhœas and dyspepsias of infancy. I recall several babies whose lives I believe I could have saved, had I known, ten years ago, what I do now of the ready adaptability of Lactopeptine to infants) ailments.—R. WALKERS BEERS, M. D., in the *Medical Brief*.

Angola, La.

WARTS.

It is now fairly established that the common wart, which is so unsightly and often proliferous on the hands and face, can be easily removed by small doses of sulphate magnesia taken internally. M. Colrat, of Lyons, has drawn attention to this extraordinary fact. Several children treated with three-grain doses of Epsom salts, morning and evening, were promptly cured. M. Aubers cites the case of a woman whose face was disfigured by these excrescences, and who was cured in a month by a dram and a half of magnesia taken daily. Another medical man reports a case of very large warts, which disappeared in a fortnight, from the daily administration of ten grains of the salts.—*The Medical Press.*

A NEW TREATMENT OF GONORRHŒA.

Castallan, of St. Mandrier Hospital, starting with the view, now popularly entertained, that gonorrhœal urethitis is a parasitic disease, and being led by observation to believe that the microbe can only live in an acid medium; finding, moreover, that in this disease the discharge is, as a rule, acid, proposes to treat gonorrhœa in the acute stages by urethral injections of sodic bicarbonate, three or four injections being made daily of a one per cent. solution. For this treatment, which is but a logical interference from the premises, he claims remarkable success, although the cases on which it has been tried in St. Mandrier, as yet, number only a dozen. The injections of bicarbonate sodium are commenced as soon as the discharge appears, or the patient comes under observation; the urethal secretion is tested every day with litmus-paper, and the injection is kept up till the discharge becomes alkaline or neutral. For internal treatment the patient is given flaxseed tea, with occasional doses of bromide, if there seems to be any indication for the sedative effects of this salt. His conclusions are as follows:

1. The urethral pus in the first stages of the disease is generally, if not invariably, acid; this acidity is quite pronounced.

2. The treatment by bicarborate of sodium rapidly lessens the discharge; it also rapidly diminishes or removes the pain in micturition.

3. In old urethrites, and those which have been treated by the usual injections, it speedily brings about a cure.—*Boston Medical and Surgical Journal.*

THE TREATMENT OF RHEUMATISM IN THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

Dr. Osler employs in mild cases, with only one or two joints involved, and the temperature not above 102° F., the citrate of potash in 3 ss doses every four hours. If there is much pain and the patient is restless, Dover's powder grs. x at night. In more severe attacks, with polyarthritis, and fever above 103°, he orders salicylate of sodium grs. xv every two hours, with a similar quantity of citrate of potash. The important influence of the

salicylate is believed to be in the reduction of the pain and fever. It is not thought to have much influence in lessening the duration of disease; and, on the other hand, when pushed for many days and in large doses, it is thought directly to favor the occurrence of relapse. Hence, as soon as the pain is relieved, the amount of the salt is reduced, and it is stopped as soon as possible. It does not probably influence, one way or the other, the occurrence of endocarditis. When the temperature is above 103. 5° antipyrin, grs. xx, is ordered. With fever of 105° the cold pack is employed. Lemonade and carbonated waters are allowed freely. An unstimulating liquid diet is given. Blankets are preferred for the bedding of the patient. Special care is enjoined in changing the clothing, and a wad of cotton-wool is placed over the front of the chest, The joints are wrapped in cotton-wool, or when very painful in spongiopiline, or flannel, soaked in Fuller's lotion (hot) (Liquor Opii Sedativus, ℥ j; Potass. Bicarb., ʒ iv; Glycerin., ℥ ij; Aquæ, ℥ ix). If the salicylate and the local application fail, as they sometimes do, to relieve pain, opium is freely given. During convalescence iron and tonic doses of quinine are ordered.—*Medical News.*

WHAT CAUSES WEAK AND TIRED EYES.

Eyes are made to see with, and they are so constructed naturally that they perform this function without effort and without labor. In its passive or quiescent state the eye is an instrument, as the opticians say of their lenses, "corrected and adjusted for distance," and it consequently images to the brain all that is within the field of vision without strain or effort. When a person fixes his eyes upon a distant object, and looks steadily at it for any great length of time, the organ itself does not tire of seeing, but the muscles which control their movements and hold the balls fixed tire of the strain thus imposed, just as any other voluntary muscle tires of being held rigidly in one position or engaged in one act for any considerable period. The visual apparatus would continue to see and report to the brain for an indefinite time, did these directing agents not tire of their task.

But while this is true of vision at a distance, it does not hold good of objects held very close to the eyes. In this case the muscles are again the seat of weariness, but from another cause. The balls must not be converged, and the focusing apparatus continuously readjusted for near distances. All this must be accomplished by muscular action. A person cannot hold his arm straight out from his body for an indefinite time; it will go down in spite of his will, after the expiration of a certain period, varying according to strength, practice, etc. So it is with the muscles which perform the complicated action of adjusting the focal distance of the eyes in the observation of very near objects. They perform the functions when ordered, and maintain their action for a certain limited space of time, but they soon weary and demand rest, which they get by relaxing. The moment that relaxation occurs the proper visual focus is destroyed, and can only be restored by a readjustment, which means a fresh demand upon the already fatigued focusing muscles.

Weakened and tired eyes, therefore, result from overworked or defective adjusting muscles, and not from the "seeing portion" of the apparatus, or the retina, which does not tire. This enables us to formulate the maxim that whenever an eye sees perfectly for one moment of time, it is almost positive proof that there is no organic disease of the visual apparatus proper. We may add that the condition of vision, known as "weak" or "tired eyes," is nearly always the result of farsightedness, which necessitates constant and excessive action on the part of the adjusting muscles to accommodate the organs to the vision of things near to them. The treatment of this condition, therefore, must be addressed to the muscles, and in cases of farsightedness the selection of proper glasses is the only thing to do. —*St. Louis Med. and Sur. Journal.*

ECZEMATOUS ULCERATION OF THE CORNEA; ECZEMA OF EAR AND SCALP; DIAGNOSIS AND TREATMENT.

Children are particularly liable to acute and chronic eczema of the face, scalp and ears, and the eruption on the surrounding skin is almost certain to excite ulceration of the cornea of one or both eyes. The conjunctiva, being continuous with the skin, sympathizes very intimately with any irritation thereof, and is consequently subject to the same eruptions. Thus when an eczematous eruption reaches close to the margins of the lids the conjunctiva becomes intensely red, and is soon itself invaded by the eczema, and the appearance of the disease in that part of the conjunctiva which covers the cornea is immediately followed by ulceration of the latter. These ulcers are frequently multiple and are always the cause of great suffering, being attended with profuse lachrymation and extreme photophobia. When the lids are forcibly separated tears gush out, and the little patient screams with agony caused by light. This condition is called eczematous keratitis or eczematous ulceration of the cornea. It is frequently most persistent and difficult to manage, but the prognosis is always favorable.

Eczema of the scalp is quite common, particularly in the neighborhood of the auricles, and often extends to them, covering one or both ears. The disease, while painful and unsightly, is by no means dangerous, except in its relation to the eyes, as explained above.

In the treatment the *only thing* to be used in the eye is a solution of atropine, from 1 to 4 grains to the ounce of water, according to the age of the patient. It should be dropped into the eye from three to five times a day, and to have any effect,

must be gotten well into it. The child's head must be firmly held, and the lids forcibly separated before the attempt to apply the remedy is made.

The treatment of the surrounding skin, or of the disease itself, is not so simple a matter. The nature of eczema is to extend in one direction while drying up in another, thus giving at one and the same time fresh and old eruptions, the first being covered with moisture and the latter with scabs or scales. The condition determines the treatment of the part. The first thing to be done is to thoroughly clean the whole surface. Where the eruption has extended to the scalp the hair must be closely cut away. All dry crusts that can, without using too much force and exciting too much pain and bleeding, must be removed. The whole surface must be brushed over with a strong solution of nitrate of silver (from 20 to 40 grains to the ounce of water). The silver solution must be applied freely, the brush being carried several times over every portion of the surface. The caustic is more particularly indicated in the moist or fresh stage, but the areas of moisture and dryness are so interwoven that it is best to go over the entire affected surface. The caustic application must be followed by one of oxide of zinc ointment (made with vaselin), which should be gently but thoroughly applied and rubbed in. The caustic should be applied but once daily, but the ointment should be repeated at least thrice within the same period. If properly applied the latter soon saturates the crusts which it was impossible to remove at first, softens them up and loosens them, so that they will separate and drop off spontaneously, and will not reform. When the moisture has disappeared the caustic application must be discontinued, but the ointment must be kept up until the skin is entirely healed. As the disease leaves the skin the ulcerations on the cornea disappear. When this occurs the use of the atropine solution should, of course, cease. If there be any otorrhœa it must be treated in the usual way, and due attention must be paid to the nourishment of the patient under all circumstances. The diseased skin must not be covered. It should be left open to the free contact of the air at all points. So far as I can now remember this method of treatment has been uniformly and invariably successful in my hands.—*St. Louis Med. and Sur. Journal*

SOME SURGICAL HINTS.

Prof. John Chiene, in an admirable series of practical notes on every day surgery, makes the following suggestions in the *Edinburgh Medical Journal:*

In wounds of the face the best stitch to make is horse hair. Unless the wound is of considerable size no form of drainage is necessary. The best dressing is the pad of salicylic cotton wool or corrosive wool, fixed in position with flexible collodion. The introduction of the sharp spoon into the surgical practice has greatly simplified the treatment of lupus. In the use of the sharp spoon special care must be taken to scrape away the raised edges of the lupoid ulcer, as it is here that the pathological change is advancing. This is best done by scraping from the sound skin toward the centre of the ulcer. After the new formation is completely removed, the best application is a powder, which has been introduced into the surgical practice by Dr. Lucas Championnier, of Paris. It consists of light carbonate of magnesia, which has been impregnated with vapor of eucalyptus, powdered benzoin and iodoform in equal quantities.

In a reduction of a dislocation of the lower jaw, the patient should be seated on a low stool before the surgeon. In this way the surgeon gets sufficient leverage, standing above the patient, and the reduction of the dislocation is simplified.

In the division of a tight frænum of the tongue, when the child is tongue-tied, care must be taken not to use the scissors too freely. All that is necessary is, standing behind the patient, to nick the anterior edge of the frænum with the scissors, and to tear with the finger nail the remainder of the band. In this way hemorrhage which is apt to be troublesome is prevented. In the removal of an elongated uvula after you have grasped the apex of the uvula it is to be drawn forward and, rendered tense before division. If it is simply grasped and attempt made to divide it in its normal position, it is not an easy matter to effect the object desired. When it is rendered tense, the operation is a very simple one.—*New Eng. Medical Monthly.*

Dr. Livezey writes: "While wintering in Florida I met with my annual patient, a young lady of twenty-eight, from Chicago, who was sent hither three or four years ago in order to pass out into the "spirit land" comfortably, who now being troubled with poor appetite, a slight but distressing nausea, great debility, irregular menstruation, excessive cardiac action on the least exertion, etc. I ordered 1 oz. bottle of Lactopeptine of the N.Y. Pharmacal Association's manufacture, and she improved at once. Soon after she met a lady friend, who told her she ought to take Lactopeptine, stating what wonders it had done her, who was troubled "just the same way" (of course). "Why bless me," said my patient, "that is just what my doctor prescribed for me, I am doing nicely." By the time she finished the small vial she declared she never felt better in her life, her appetite being regular, and everything O.K.

N.B.—She has taken since Lactopeptine, Elixir Calisaya, Iron and Bismuth, with excellent results, —*The Medical Summary.*

CONIUM FOR SLEEPLESSNESS.

Drachm doses of fluid extract of conium allay and often cure sleeplessness, and are useful in chorea, spasm of paralyzed limbs, and general irritation.—*Medical World.*

PSOAS ABSCESS; WHEN AND HOW TO OPEN IT.

At a recent meeting of the British Medical Association, Mr. Edmund Owen read a paper on the above subject. Mr. Owen said there was no disease the treatment of which had derived a greater impetus from the introduction of antiseptics than psoas abscess. By antiseptics he did not mean the use of the spray. The spray was now cooling down in more senses than one, and the surgeon did not now have to look through a cloud of carbolic vapor at his patient. By the use of antiseptics he meant antiseptics as used by the great masters in surgery, whether by Tait, Gamgee, Savory, or Lister. Twenty years ago every surgeon preferred to leave a psoas abscess alone, so long as it remained unopened. Stanley, writing forty years ago, said psoas abscess might disappear. Could it? Mr. Owen said that in an extensive out-patient experience, extending over years, he had only seen one case in which, after a fusiform tumor had been detected ascending along the iliac fossa, he had seen it disappear. Aspiration was useless, for it refilled. When evacuation of the abscess was performed, it should be done thoroughly, and no useless temporizing measures made use of. During delay the pus would be burrowing out for itself an extensive ramifying cavity. A free anterior and posterior opening should be made, and the wound thoroughly drained. The sac should be washed out with a warm antiseptic lotion, and a drainage tube the size of a cedar pencil passed through. The wound should be covered with sublimate gauze, then some oakum placed over it, and the dressings changed as seldom as possible. He had employed as the antiseptic lotion a warm solution of corrosive sublimate (1 in 1,000). He should, however, in future, discard the use of the sublimate, as he had had a case which died in four hours with black urine, due, he believed, to the absorption of the sublimate. Mr. Owen, in concluding, summed up his conclusions as follows:

1. Spontaneous absorption of psoas abscess is impracticable. Sooner or later it must be evacuated, either by nature or art, and the advantage is on the side of art.

2. The sac should be opened both in front and at the back, and irrigated. For a small abscess a single opening at the back might suffice.

3. Antiseptics should be employed.

4. The operator should bear in mind that pus might collect on the opposite side after evacuation of the abscess. If any rise of temperature take place, a second abscess should be suspected, and if found, evacuated at once. Bilateral abscesses should be attacked simultaneously, as their cavities frequently communicate. In reply to a query from a member as to the source of his method, Mr. Owen replied that was neither English, French, Scotch, nor Italian, but Welsh, thereby signifying that the idea was his own, and that he had not borrowed it from any one.—*New York Medical Record.*

TREATMENT OF ACUTE TONSILLITIS.

Dr. John Brown states, in the *British Medical Journal*, that it is a rare event for suppuration to occur in acute tonsillitis, if treated early with the following mixture:

℞.—Sodii salicylat..... ... . ʒ iss.
Potass. bicarb ..... ʒ iss.
Tinct. aconit..... .....m xl.
Liq. opii sed..... ʒ ss.
Sp. chloroform..... ʒ ii.
Aquæ, q. s. ut ft .....f ʒ viij.—M.

Sig.—One to two ounces every two or three hours for the first thirty-six hours.—*Memphis Medical Monthly.*

A RAPID METHOD IN THE TREATMENT OF FRACTURES.

Dr. von Donhoff, of Louisville, thus describes a rapid method of treating fractures:

"1. Strips of sole Leather or gutta percha (tin will answer also) of suitable breadth and length being at hand, these are immersed in hot water and adjusted, by means of a roller, to the site of the fracture, previously reduced and properly swathed in cotton wool; the latter should be secured in position by a few turns about it with sewing thread. [Anæsthesia is a *sine qua non* to the proper manifestation and reduction of fractures.]

"2. If no suggestive incident intervene, such as shortening, angularity, or great uneasiness and pain, the *first* dressing, in cases of fracture of the shaft of long bones, should not be removed until the tenth day, but should never be permitted to remain longer than the sixth day in similar injuries of joints.

"3. On the fourteenth to the twentieth day, barring cases in which untoward diathetic or local influences have been demonstrated to exist, it will be found that the fragments are fixed, and that the dressing may be dispensed with altogether, except in fractures involving joints; in these the splints, properly stitched together, should be readjusted on going to bed, in order that the unconscious and possibly violent movements of the patient may not prove disastrous.

"4. Gentle, passive motion of fractured joints should be begun at least as early as the sixth day after the first dressing, and practiced every second day thereafter until the fourteenth, increasing the degree of motion as may be suggested by the judgment of the surgeon. After this date, the dressing being left off, the matter of moving the limb may be relegated to the inclination of the patient, unless he be too timid, when he may safely be encouraged to handle light objects and practice normal motions of the limb.

"5. The average duration of treatment need not exceed twenty-eight days, under ordinary circumstances.

"The above rules of practice have proven equally reliable in the treatment of compound fractures produced, in osteotomies done for the correction of deformities near the ends or in the continuity of long bones.

"6. The posture of the limb should be that best adapted to muscular equipoise—straight, or in an obtuse angle."—*American Medical Digest.*

CHLOROFORM IN LABOR.

At the last meeting of the State Medical Society of New-York, Dr. Fordyce Barker read a paper entitled, "Is the danger from post-partum hæmorrhage increased by the use of anæsthetics during parturition?" This subject is of great practical importance, and Dr. Barker has brought the treasures of a large and successful experience to its elucidation. His paper is eminently practical, and will secure a wide reading, and will, we doubt not, lead to the more frequent employment of anæsthetics in labor. Dr. Barker regards chloroform as the best and safest anæsthetic in obstetrics; since 1850 he has not used ether. He presents strong arguments for this selection. He has never been able to find any statistical evidence in proof of the statement constantly made in obstetric literature that anæsthetics increase the danger of post-partum hæmorrhage. He expresses the firm conviction that no woman under the care of a watchful, prudent, and competent obstetrician ever ought to die from post-partum hæmorrhage, due solely to uterine inertia or ataxy. He also makes the important statement that uterine inertia, the fountain of post-partum hæmorrhage, is often but another name for uterine exhaustion, and this is certainly much less liable to occur when the nerve force and vital powers have been saved by the use of an anesthetic. While admitting that chloroform, in some cases, prolongs labor, and that uterine exhaustion often is the result of prolonged labor, he is satisfied that this apparent objection is more than counterbalanced by the good obtained by its use. As the result of his experience, he asserts that chloroform shortens labor in a greater proportion of cases than it retards it.

"He is certain that it does in all those cases where the pains are diminished or suspended by extreme sensitiveness and fear of pain, by vivid moral impressions of hysteria, or by pains resulting from the coincidence of some malady, either existing antecedent to, or appearing during labor, such as rheumatism of the uterus or other muscular tissues, or sharp pains in the back or abdomen distinct from the pains from uterine contractions, gripings in the intestines, or the cramps which are occasionally produced by the pressure of the child's head on the sacral nerves; and, finally, in all those cases where inefficient uterine action results from loss of sleep and extreme exhaustion from a prolonged first stage; and in many cases where the labor is retarded by rigidity of the os uteri or perineum."

He has attended a number of patients who in previous confinements had alarming post-partum hæmorrhages, though taking no anæsthetic, who have escaped this accident in labors in which chloroform was used. A peculiar idiosyncrasy, or former tendency to hæmorrhage or extreme feebleness, the reasons given for withholding an anæsthetic in former labors are the very strongest indications for the careful administration of chloroform. In private practice he has only had one case of post-partum hæmorrhage, and in this case no anæsthetic was used, as the child was born before he had time to make an examination. Dr. Barker is convinced that the prevalent opinion that chloroform is dangerous for any woman with heart disease is erroneous. He has had a number of cases of labor dangerously complicated with organic heart troubles, which terminated favorably, as he thinks, solely from the use of chloroform. In an experience of thirty-seven years, using chloroform in several thousand cases, he has never in a simple case had reason to regret its use. The conclusions of Dr. Barker, drawn from such a large experience, will be most acceptable to the profession.—*South Western Medical Gazette.*

TO PREVENT MAMMARY ABSCESS.

Although Dr. Goodell ridicules the idea of aborting mammary abscesses, which he does not think can be done, yet Mr. Miall (*British Medical Journal*) says that when mammary abscess is on the point of forming, he has frequently seen all the symptoms rapidly disappear in a few hours, under the influence of fomentations with hot water and carbonate of ammonia. He uses an ounce of the carbonate in a pint of water, and when solution is accomplished the temperature of the fluid will be hardly too high for fomentation to be commenced, with cloths dipped in the liquid. He applies them for from half an hour to two hours, at the same time protecting the nipples. He has often had immediate relief, and seldom requires to make more than three applications.

A SUGGESTED ALTERATION IN THE COMPOUND LIQUORICE POWDER.

Having found that the above preparation produced very severe griping in many instances where he had ordered it, the griping being particularly severe in some of his younger patients, Dr. Martin Oxley (*Lancet*) had ordered the following formula for some time past, in which anise fruit is substituted instead of the fennel, and one-fourth part of ginger is added. The altered formula runs thus :—senna and liquorice-root of each 2 parts; anise fruit and sulphur, of each 1 part; sugar, 5¾ parts; ginger, ¼ part. This altered preparation is quite as satisfactory in its laxative properties, is less liable to gripe. and is as pleasant to take as the officinal powder, and he would suggest its trial in cases where the powder as now prepared produces the disagreeable effects to which he has referred. —*Phil. Med. and Surg. Reporter.*

VARICOSE VEINS AND THEIR TREATMENT BY OPERATION.

By Kendal Franks, M.D.

Varicose veins may result when the veins are no longer equal to the pressure of the blood within them. This may follow from two causes —one *extrinsic*, when from remote cause an unusual amount of pressure is thrown upon the veins, such as pressure upon the iliac veins, due to overloading of the intestines or to some abdominal tumor, or, as in some forms of heart disease, cirrhosis of the liver, and such other obstructions to the free course of the blood in the veins. Or the cause may be *intrinsic*—that is, for some reason or other, the veins have lost their tone and their elasticity, and are no longer capable of resisting the normal pressure from within.

Whatever the agency at work may be, the result is the same—namely, that the balance between the elasticity of the walls of the vein and the intravenous pressure is lost, and gradual dilatation and distension of the veins ensue. This loss of balance will be felt, of course, wherever the pressure is greatest; and these situations are those, in the dependent parts of the body, where the column of blood is the longest. If we take a long **U**-shaped tube, and almost fill it with water, the fluid in one limb will rise to the same height as in the other, but the pressure of the fluid on the sides of the tube will be greater the nearer we approach the base of the **U**—that is, the longer the column of fluid is. So it is in the veins. The column of blood in the veins is supported by the column of blood in the arteries, but the pressure in the veins will depend on the length of the column of blood it has to support. No doubt nature provides a means of taking off this excessive pressure by supplying the veins with valves, so that under normal circumstances the vein has only to support the column of blood that lies between two pairs of valves. But nature has also endowed the veins with the power of distending, so as to be able to accommodate an increased quantity of blood, should there arise any temporary obstruction to its onward flow through the heart. Now, when the veins so dilate, the valves within them are drawn apart, and so allow of regurgitation. This temporary distension of the veins and insufficiency of the valves is quite a normal process. But suppose that the obstruction to the onward flow of the blood, due to one of the extrinsic causes, is permanent, or that the condition of the vein walls is such that after distension their elasticity has become so impaired as to prevent them returning to their usual size, then the valves remain permanently apart, and are no longer capable of supporting the column of the blood. This throws an extra weight on the valves below, and these again yielding, the functions of the veins become more and more impaired. Now, in obedience to the general law in the body, that when a part loses its function it gradually wastes, so in the veins we find that the valves, being unable to accomplish their purposes, gradually atrophy, and may ultimately either disappear altogether, or their former existence be only recognized by thin fibrous bands on the inside of the vein. Hence it is, as Gay says, that "as a rule, veins that become varicose are destitute of valves."

Thus it happens that veins below the original site of lesion have a permanently increased pressure of blood thrown upon them, and this alone will eventually cause them to become varicose, even though they were themselves originally healthy, and although the original cause of the obstruction to the circulation may have disappeared. Let me here give an illustration of what I mean. Suppose that the original cause of increased pressure in the veins of a limb has been due to constipation, and the pressure of intestinal accumulation upon the iliac veins—suppose that this has continued long enough to cause varicosity in some of the veins of a leg, say below the knee; after a time the valves in these veins have became atrophied, and the veins permanently dilated—now, suppose that under proper treatment the constipation has been cured, will this allow the veins to resume their normal condition? No; on the contrary, this very destruction of the valves has thrown a permanently increased pressure on the veins below them, and this alone will cause them to undergo the same process, unless means be adopted to relieve them of the unusual pressure.

Now, to the sequel of events following on a vein in the leg becoming varicose. The circulation in the part is checked, the nourishment of the part is, therefore, seriously interfered with. The skin first becomes discolored and suffers from a form of eczma. Finally, the skin supply is so deficient that the part sloughs, and we have, as a consequence, an ulcer. Added to this, that the vein wall may suffer, and terrible hæmorrhage may ensue, not only from the lower radicals but from the trunk, in which there are no valves to check the backward flow. Now, under these varying circumstances, what treatment should we adopt? In the early stage, when as yet the vein is to a limited extent involved, but before the skin has suffered in any way, there can be no question that palliative measures should be adopted, and of these, in my opinion, the best is the elastic bandage. Its object is to yield that support to the veins, which their walls are unable to afford; and by such means, provided the offending cause be removed, and provided that the valves have not been destroyed, we may even hope for a cure ultimately. I will go further and say that in old and very debilitated subjects, such palliative measures are preferable to operation, under all circumstances. Again, if the varicosity of the veins in the legs be due to an irremediable extrinsic cause, operation is obviously excluded; as, for instance, if the condition be due to pregnancy, to pressure of an abdominal tumor on the iliac

veins, to disease of the heart, to cirrhosis of the liver, and so forth. Therefore, in all cases before operative measures be adopted, it will be necessary to satisfy ourselves first that such causes do not exist. From these exceptions we may deduce the cases in which I believe operation is advisable. Firstly, the varices must be due to intrinsic causes, or to remediable extrinsic causes, such as constipation, the pressure of an ill-fittting truss, tight-garters, or too long standing. In these latter cases the cause must be removed. Then, again, the patients should be young, or healthy adults; and let me here say that, in my opinion, comparatively slight varicosity may induce us to operate in a young subject, which in an advanced adult would not justify us.

Subject to the conditions already laid down, if, in a healthy adult, we find a varicose condition of the veins accompanied by an ulcer, or with a brawny condition of the skin, or with eczma, if it be sufficiently extensive to give rise to pain or discomfort, I think operation is the best treatment.

[The writer describes various methods of operating, which have not proved very satisfactory, and continues]:

I have full notes of 18 cases which I have treated by antiseptic excision, several cases the notes of which I have not preserved. In no case, have I seen "phlebitis, erysipelas, or pyæmia" follow as a result. The patient being placed under ether, I begin by shaving the parts where I purpose to make the incisions. The skin is then carefully washed with corrosive sublimate solution, sometimes oil of eucalyptus is also used. I then usually fasten a band round the limb, immediately above the knee so as to distend the veins sufficiently to be able to trace them accurately. If the veins are extensively varicose, it is much better practice to excise the chief radicals at intervals, removing two or three inches at each place, than to attempt to excise a long piece of vein. Nothing is gained by the more extensive incision. Having selected the place for incision, a clean cut is made through the skin, and almost immediately the swollen vein appears. The subcutaneous tissue over it is divided on a director. Should the vein be cut, it is at once seized with Spencer Wells' forceps. A strong cat-gut ligature is passed round the vein at its lower end. The vein above this is seized with the forceps and ligature. It can then be easily pulled out of its bed. Any radical going into it are ligatured and cut off; finally, the vein is tied at the upper angle of the wound and the piece excised. When the veins are tough with hypertrophied coats the proceeding is very simple; but when the veins are thin, especially if adhering to the skin, a good deal of care and patience are required. The wound is irrigated with corrosive sublimate solution, 1 in 2,000, a little iodoform dusted over it, and the edges brought together. In my earlier cases, I used to insert a drainage tube, but I now think it is quite unnecessary. The wound is then enveloped in some of the antiseptic dressing, whilst a second and a third piece of the vein is treated in the same way, if necessary. If both legs are involved, the second leg is treated at the same time. Both legs are then bandaged from the toes to above the knee. As a rule, the dressings are left undisturbed for eight or ten days, and when removed we generally find the wounds healed by first intention. In a few cases some suppuration occurred, but this was generally traced to some deficiency in the dressings, at a time when the dressings were improperly prepared. This only delayed the process of healing, but in every case the asepsis of the wound had been sufficient to protect the veins from contamination.

The beneficial effects have been in many cases as marked as to dispel all doubts as to the efficiency of the cure. A man, æt. 36, perennially on inmate of the Adelaide Hospital for varicose ulcers, refused several times to have an operation performed. Two years ago he presented himself again, with the ulcer as bad as ever, the skin brawny and discolored, the edges of the ulcer hard, elevated, and inflamed. He consented to an operation for the cure of the veins. I kept him in bed for several weeks, and treated the ulcer until it was about the size of a florin, and was quite healthy. I then had him placed under ether, and excised portions of those veins which seemed to be chiefly connected with the ulcer. All the veins operated on were above the ulcer—that is, on the side nearest the heart. The operation was performed as usual, and the dressings applied were not disturbed for a fortnight. They included the ulcer. When they were removed, the ulcer was found to be perfectly healed beneath them, and all the incisions—three in number—had healed by first intention. I allude to this case because it goes to prove that these ulcers are caused by the pressure in their efferent veins.

Early in November last, I operated on a young gentleman, æt. 25, the subject of extensive varicose veins in the right leg. The saphena vein at the bend of the knee was very large. He had previously been operated on by a surgeon in Dublin twice by the subcutaneous needle method, for the obliteration of the saphena vein at the knee. On each occasion three needles were passed beneath it at intervals of half an inch, and yet when I saw him this vein was as patent and as varicose as if it had never been touched, though the skin over it showed marks of where it had been constricted. I excised portions of the three most aggravated varices I could find. The wounds all healed by first intention, I saw this patient to-day. The veins operated on are all obliterated. He told me he had lost the bursting feeling in his leg from which he used to suffer, and that he had discarded the elastic stocking. The veins unoperated on remain varicose, neither better nor worse than when I saw him in November and is he so pleased with the former operation that he wishes all the

veins to be treated in a similiar manner. This case illustrates the superiority of excision over the constriction method.

Let me say a few words as to the permanency of the cure. If the varicose condition of the veins is due to a cause which we cannot hope to rectify —an extrinsic cause—we cannot expect the operation to be successful. But when we can remove the cause, and when, at the same time, we treat the effect, I consider that we have just grounds for assuming that the cure will be radical. Two years ago I operated on a young man, æt. 26, for extensive varices of one leg. A year and a half later he wrote to me to express his great delight at the permanency of the cure; that since the operation had been performed he had been able to take long walks, to stand the greater portion of the day without the slightest inconvenience, or without any sign of fresh varices appearing. I could point to many similiar cases.—*Dublin Journal Medical Science*, May, 1886.

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MONTREAL, APRIL, 1887.

ANNUAL CONVOCATION OF THE MEDICAL FACULTY OF BISHOP'S COLLEGE.

The annual convocation of Bishop's college, for conferring degrees in medicine, took place on the 31st March, in the Synod hall, Montreal. There was a very large attendance of the students and their friends, among whom the ladies were in the larger proportion. An interesting feature of the convocation was the conferring of a degree on a colored student from the West Indies—a fine, intellectual looking young man—the son of a wealthy merchant, who passed through the college with honors.

Mr. R. W. Heneker, chancellor of the college, presided. Among those present on the platform were Rev. Canon Norman, vice-chancellor; Dr. F. W. Campbell, dean of the faculty of medicine in college; Professors McConnell, Saunders, Trenholme, Wood, Baker Edwards, Lapthorn Smith (acting registrar, in place of Dr. Kennedy, who was absent in Colorado), Reddy, Rowell, G. T. Ross, Proudfoot; Rev. Principal Adams, of Bishop's college school, Lennoxville; Rev. Rural Dean Lindsay, Mr. Ed. Chapman, M.A.

REPORT OF SESSION 1886-87.

Dr. Campbell, dean of the Faculty, read the report, which was as follows:

The number of matriculated students for the session 1886-7 was 31, being an increase of 8 over last year's attendance. Of these, 1 comes from the United States, 6 from Ontario, 16 from Quebec, 2 from the West Indies, 1 from British Guiana, 3 from England, 1 from Italy, and 1 from India. Sixteen of our students are residents of Montreal.

The following are the results of the examinations:

Botany—F. E. Bertrand, Prescott, Ont.; F. Coote, Quebec; D. H. Judd, Mallorytown; W. N. Smiley, St. Lambert; J. M. Jack, Montreal; G. J. Tait, Jamaica, W. I.; H. N. Spooner, Highgate, Vt.; D. Macrae, Montreal.

Practical Chemistry—J. M. Jack, Montreal; C. A. Lauchlan, Montreal; C. E. Vidal, St. John; L. M. Clark, Kingston, Jamaica; T. S. Nichol, Montreal.

Practical Anatomy—T. S. Nichol, L. M. Clark, Frederick Taylor.

Anatomy—First class honors: L. M. Clarke, T. S. Nichol; second class honors: F. Taylor, Shannonville, Ont.

Physiology—C. E. Vidal and L. M. Clark, first class honors; C. A. Lauchlan, second class honors; passed T. S. Nichol, J. M. Jack, F. Taylor, J. Rohlehr (New Amsterdam, B.G.).

Materia Medica and Therapeutics—Messrs. Vidal and Clark, first class honors; passed, Mr. Tait (Jamaica, W. I.).

Chemistry—First class honors, Messrs. Clark, Lauchlan, Vidal, Nichol; second class honors, Messrs. Taylor and Jack.

Hygiene—First class honors, Mr. Jack; Messrs. Laurie (Quebec), Coote (Quebec), Judd, Vidal, Clark, Taylor, Smiley, Bertrand, Nichol, Elliott (Quebec); passed, Messrs. Tait, Macrae and Spooner.

Medical Jurisprudence—Mr. Pickel (Sweetsburg, P.Q.), first class honors.

Mr. L. M. Clark has passed the primary examination, consisting of anatomy, physiology, materia medica and therapeutics, chemistry, hygiene, practical anatomy and practical chemis-

try, and is entitled to the David scholarship, having obtained the highest number of marks in all primary subjects.

The following gentlemen have passed their final examination for the degrees of C. M., M. D., consisting of practice of medicine, surgery, obstetrics, and the diseases of children, gynecology, pathology medical jurisprudence, and clinical medicine and clinical surgery :—

Mr. W. E. Fairfield, of Clarenceville, Que.—First class honors and Wood gold medal, awarded to the student who has attended two six months' session at Bishop's college, and has attained the highest aggregate marks in primary and final examinations.

The Robert Nelson gold medal for special excellence in surgery is awarded to Mr. W. E. Fairfield. The contest for this medal was very keen between Mr. Fairfield and Mr. R. Campbell, the successful candidate winning it by only fifteen marks. This medal was founded by Dr. C. E. Nelson, of New York, and is awarded annually to the student standing first in a special examination in surgery, written and practical. No one is allowed to compete unless he has attended at least two sessions at Bishop's college, and has attained first class honors in primary and final examinations.

Mr. Rollo Campbell, of Montreal, has won the Chancellor's prize for the best final examination, the Wood gold medallist not being allowed to compete, and has passed with first class honors.

Mr. A. E. Phelan, of Montreal, first class honors.

Mr. A. P. Scott, of Montreal, first class honors.

Mr. Rohlehr, of New Amsterdam, British Guiana.

In order to pass in any subject, a candidate must obtain at least 50 per cent. of the maximum marks ; second class honors require at least 60 per cent. ; first class honors at least 75 per cent.

PRIZE LIST.

Wood gold medal and Robert Nelson gold medal, Mr. W. E. Fairfield, of Clarenceville, Que.

Chancellor's prize for best examination in final subjects, Mr. Rollo Campbell, of Montreal.

David scholarship, Mr. L. M. Clark, of Jamaica.

Practical anatomy, senior prize, Mr. T. S. Nichol ; junior prize, Mr. C. E. Elliott.

Botany prize, Mr. F. Bertrand.

THE CHANCELLOR'S ADDRESS.

Chancellor Heneker, in the course of his address, said :—The work of Lennoxville, comprising the Arts and Divinity Faculties, is very satisfactory. The number of students, although not so large as could be desired, is still large enough for satisfactory work, and perhaps as large as may be reasonably expected in a new country, where but few men use the advantages offered of high class education, for the mental training it affords, independent of any special pursuit in life.

CONFERRING DEGREES.

The graduates were then called before the chancellor, and, after having been duly sworn in by the dean, they received their diplomas. The prize winners were heartily applauded as they advanced to the platform.

THE VALEDICTORY.

Dr. A. E. PHELAN, of Montreal, was called upon by the chancellor to read the valedictory address on behalf of the graduates. The address was well composed, and Dr. Phelan was frequently interrupted by applause—demonstrative if not boisterous—from his fellows initiated into the deep secrets of the medical profession. In the course of his address he bore testimony on behalf of the class of '87 to the pains which the professors took with the students, and to their zeal and their able instruction. The professors were ever ready to remove obstacles from the paths of the students, while at the same time they were foremost in advancing medical education in Canada. Dr. Phelan, in conclusion, told of the pleasures of their college life in Montreal, and was greeted with applause at the conclusion of his valedictory.

FAREWELL FROM THE PROFESSORS.

Professor Rowell delivered the farewell address to the graduates. After complimenting the members of the class of '87 on their industry and zeal in pursuit of their studies, he said that the medical graduates of to-day were better fitted to enter on their career in the profession than the graduates of thirty or forty years ago. A more extensive examination was now required in the ever growing knowledge of the profession, and a four years' course in a medical college was now a necessity. The professors of Bishop's college have not been backward in keeping pace with the times.

During the winter sessions they applied themselves to their special departments, and during the summer months many of them went abroad to seek instruction and experience in the older schools and hospitals of the continent. The students of Bishop's college had reason to congratulate themselves for the facilities of hospital inspection placed within their reach, and which were perhaps better than those of any other college. Not only had they the Montreal General hospital, but the Hotel Dieu and the Western Hospital. He asked graduates to remember their *alma mater*, and to do all in their power to reflect honor on it.

THE REV. CANON NORMAN,

vice-chancellor, then addressed the convocation. To their worthy chancellor, whose absence they missed last year, was to be attributed a large degree of the success of Bishop's college, and the speaker wished to bear testimony to the help which Chancellor Heneker was to the cause of true education in the province of Quebec. He congratulated the college on the increase in the number of students, and he could personally bear testimony to the unequalled courage and the manly endurance displayed by the professors of the faculty of medicine in the face of great difficulties. They knew that Bishop's college would have an up-hill fight when it was founded, but they had managed to surmount the difficulties, and it would be hard to find a body of men with such zeal and devotion as the professors in medicine. (Applause.) He was quiet satisfied that they would have a larger number of students next year, and he congratulated the college on having such a remarkably intelligent and clever class of freshmen. He was glad to see that a number of the graduates in medicine were also graduates in arts at Lennoxville.

In conclusion he trusted that the benevolence of the friends of the institution would soon enable them to build a hall of their own for the medical faculty, so that the money now expended on rent might be devoted to the cause of science. (Applause.)

The Rev. Principal ADAMS delivered an eloquent address.

Dr. LEO. H. DAVIDSON, in an admirable address, spoke of the advantages conferred by the college and its success in the cause of education. He wished the graduates "God speed" in their new life.

The company then sang the national anthem, and the convocation was brought to a close with prayer.

THE STUDENTS AT DINNER.

In the evening about fifty of the students and their friends sat down to dinner in the Richelieu hotel, which was done up in Durocher's best style. Mr. F. Taylor presided, and among those present were Drs. Armstrong, Perrigo, England, Longeway and others. The following toasts were proposed, and duly honored, "The Queen," "President of the United States," "The Governor General," "Our Alma Mater," "Trade and Commerce of Montreal." Appropriate speeches were delivered by the chairman and several of the graduates. The majority of the latter, in the course of their remarks, wished their confreres all success in their journey through life. Songs were also sung by several of those present. The evening passed off most successfully. The students deserve all credit for the manner in which they conducted the proceedings.

INTERNATIONAL CONGRESS ON INEBRIETY.

The Council of the English Society for the study and cure of Inebriety have completed arrangements for an International Medical Congress, to be held at Westminster Hall, London, *July 5th and 6th*, 1887. The object of this Congress is to present and discuss the problems of Inebriety medically, and from a purely *scientific standpoint*, by the best authorities, thus laying the foundation for a broader and more exact study of this subject. Papers and addresses are promised from a large number of the most distinguished physicians.

PERSONAL.

Dr. Kannon (M.D. Bishops College, 1879), who removed last winter from Montreal to Los Angelos, California, has been appointed assistant health officer of that thriving town.

The honorary degree of M.D. has been conferred by the University of New York on Mr. Lawson Tait, F. R. S., of Birmingham, England.

Dr. John Macleod (M.D., Bishops, 1877), has just returned to Canada from Australia, where he was engaged for the past ten years in practice. He has accumulated a competency, and is now *en route* to Scotland, where he intends to locate permanently.