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RECORD OF A CASE OF EXTRA-UTERINE PREGNANCY SUCCESSFULLY TREATED BY LAPAROTOMY AND INTESTINAL RESECTION.*

BY ANGUS MACDONALD, M.D., F.R.C.P.E.

Obstetric Physician to the Royal Infirmary, Edinburgh.

Mrs. S., æt. 28, residing at Comiston Mains, admitted into ward xxiii., Royal Infirmary, on 19th May, 1883, complaining of abdominal pain and swelling, œdema of left leg, and great exhaustion. Recommended by Dr. Graham, of Currie.

History of present attack.—Patient ceased to menstruate in October; up to that month she was perfectly regular. Shortly afterwards she felt great pain in the lower part of the abdomen, on two distinct occasions, both of which lasted for a week. She obtained some medicine from her doctor which relieved the pain. In December she was much troubled with vomiting and sickness, beginning in the morning and continuing during the day. This was found to have no relation to the ingestion of food. The vomiting continued until about four weeks ago, when it suddenly ceased, and has not returned. The patient says she distinctly felt foetal movement until a month ago. She is not quite sure when she first noticed it, but is quite positive as to its having been unmistakably present. In February her breasts began to swell, and continued to do so markedly. Milk could be squeezed out of them until a month before admission. Since then the breasts have become small and hard, the nipples however remaining large and prominent. Four weeks ago she was working very hard at home and thinks that she overstrained herself; she then had pains like labour-pains, and noticed that her

abdomen was beginning to swell, and felt a deep-seated pain in the lower part of it, which became so bad that she had to take to her bed. As the swelling increased she had great difficulty and pain in passing water. About a week before admission she noticed a sanguineous discharge from the vagina. A few days previously her left leg became swollen, beginning at the ankle and gradually extending upwards to the hips. Her family and previous history are good.

State on admission.—Patient pale, anxious-looking, and emaciated. The dropsy referred to in the left leg still present. Temperature varying from normal in the morning to 103° - 104° in the evenings.

Genito-urinary system.—*Sexual history.*—Patient began to menstruate at 15 years. The quantity at each period was profuse, and duration seven days. Sometimes slight dysmenorrhœa. She had one child six years ago.

Physical examination.—Abdomen generally distended; resonant all over, except just above the symphysis pubis, and toward the right flank, where it is relatively dull. Left flank is quite clear. Measurement round umbilicus, $33\frac{3}{4}$ inches.

Per Vaginam.—Vagina is short; the uterus is depressed, the vaginal portion being soft and enlarged, like that of a pregnant uterus. There is a tender fulness in the pouch of Douglas. In the right and left fornices, on deep pressure, a rounded mass can be also felt. The sound enters five inches, and communicates a feeling of increased resistance as it passes over the endometrium.

Per Rectum.—A large semi-elastic mass projects into the pouch of Douglas, flattening the rectal wall, and giving rise to great pain when touched.

Alimentary system.—The patient's tongue is red and fiery-looking. The appetite is poor. There has been considerable diarrhœa of late. The breath smells strongly of "newly-mown hay."

Circulatory system.—Palpation and percussion resonant; a soft murmur accompanies the first sound in the mitral area. Pulse rapid, rather compressible, and collapsing readily.

Respiratory system.—Normal.

Urinary system.—Urine reddish-color, slightly acid, specific gravity 1014, and contains a trace of albumen. Strict rest was ordered and milk diet. Symptoms to be met by astringents, opiates, &c., as they should arise.

*Read before the Edinburgh Obstetrical Society, 12th Dec., 1883.

From date of admission till 12th June, a varying amount of pus and blood was seen to pass from the patient's rectum. The abdomen at the latter date is found still distended, though measurement round the umbilicus is somewhat less—32 inches. The uterine tumour is still felt close to the umbilicus. The mass spoken of previously as flattening the anterior wall of the rectum is not so prominent now; it is very irregular in outline and tender to the touch. Within reach of the finger no opening can be felt on its surface. The swelling has disappeared from the left leg. Breath smell now natural.

2nd July.—Abdomen flaccid and much smaller than before; no pain is felt on pressure. In the left groin there is a feeling of increased resistance; the uterus can also be felt above the pubis. Measurement round the umbilicus, 30 inches.

Per vaginam.—The tumour is felt behind and to the right of the uterus; its surface is very irregular, and is found to extend above the brim of the pelvis on the left as well as on the right. Sound enters five inches; surface of the uterus still rough.

Per rectum.—The tumour is felt, especially on the right side, pressing on the surface of the uterus; it is tender and communicates no feeling of softening. On pressing the abdomen over the tumour, to the right of the mesial line, a peculiar crackling or crepitating sound is elicited.

5th September.—General condition of patient much improved, though the pain in abdomen during the last week has increased. Measurement round the umbilicus, 34 inches. The pain in the abdomen is increased with every attempt at motion. Bowels of late have been regular. As the patient had been on our hands since 19th of May, being now nearly five months, and though she had improved so far as her general condition was concerned and no longer showed any septicæmic symptoms, she yet suffered greatly from pain and became threateningly ill when any attempt at sitting up was made, I came to the conclusion that some active means were warranted in being taken, with the view of affording her permanent relief. As against operative measures, we had to consider the fact that at one time undoubtedly a connection existed between the sac of the tumour and the intestinal canal; but as the intestinal symptoms had of late been in abeyance, I resolved to operate.

Accordingly, assisted by Drs. Chapman, Dunlop and Playfair, on the 9th October, 1883, I opened

the abdomen, with antiseptic precautions minus the spray. Drs. Hart and Barbour, along with several other medical friends, were present. The abdomen was opened and the peritoneum reached without difficulty. It was found that the remains of the foetus were attached to the right and posterior aspects of the abdominal wall. What appeared to be an abdominal adhesion of the cyst was torn asunder, and the bones of the skull, laid bare by this means, were removed. When this apparent cyst was drawn forward, it was found to consist of about five or six inches of the small intestine, the walls of which, where they lay in relation to the abdominal walls, were thick, softened, and almost gangrenous. In the cavity in which the bones of the foetus lay there was a considerable amount of fæcal matter. A loop of intestine, which was adherent to the part above mentioned, was carefully separated from the rest, and was found to contain a fæcal fistula also. The whole of the rest of the contents of the cavity in which the foetus lay were now carefully removed, and the cavity sponged out. The portion of the intestine already mentioned, whose wall formed part of the cyst, was now cut out, and the healthy ends of the bowel brought together as completely as possible by a continuous catgut suture, care being taken to approximate the raw edges completely without including the mucous membrane. The stitches were passed very close to one another, and this part of the operation took up a considerable time. The gap in the mesentery was also brought together by continuous sutures. During this part of the operation there was some hemorrhage, which was, however, completely arrested by the pressure of the sutures. The edges of the fæcal fistula above referred to having been thoroughly rawed, were carefully brought together by catgut suture. The abdomen was now sponged dry, and the wound closed, a large India-rubber drainage-tube being introduced at the lower angle of the wound, so as to extend to the bottom of the cyst, and secured in position by passing one of the deep sutures through its texture. The temperature after the operation was 97.6°, pulse 82. In the evening the temperature was 101.4°, pulse 120 and very thready. During the night the bowels were moved four times, the evacuations being blood and mucus. Great thirst was experienced and slight sickness; slept little. Patient was kept under the influence of opium.

10th October (second day).—Temperature 99°, pulse 126.32, quick and thready. The discharge from the wound was of a dark greenish-brown colour, thick and putrid. The patient has a bad cough, which causes her much discomfort. A mustard and linseed poultice (with a piece of flannel between the poultice and the skin, to keep in the heat and to prevent blistering) was applied to her chest, which gave great relief. The thirst is still very bad, but water was given in teaspoonfuls now and then, with occasionally a small piece of ice; the ice, however, produced emesis. Towards evening the patient became exhausted. Brandy and champagne were given, a teaspoonful of brandy to a tablespoonful of champagne, every half hour. Bowels moved quite naturally. She slept a little during the day. At 11 p.m. the temperature went up to 102.2°, pulse 130. During the night the patient was able to pass urine, it having been previously drawn off. She was very restless, and so morphia was given, and she slept a few hours.

11th October (third day).—Temperature 98°, pulse 120. Stimulants were given as usual, and peptonized meat suppositories were introduced, at first every hour, and then every two hours. Sickness was caused by the brandy, so champagne was given alone. After a time that also was rejected and brandy was again given, and no sickness followed. The discharge from the wound was now found to be mixed with *fæces*, accordingly the dressing was changed from protective and salicylic wool to marine lint and oakum, which was changed every four hours, the bowels still acting.

From 12th October to 22nd October (fourteenth day).—Patient continued gradually to improve under the same treatment, sleeping slightly better and looking brighter. On the 22nd October the drainage tube was taken out. A charcoal and linseed poultice was used to remove the crust formed by the salicylic cream which I should have mentioned as having been put on. Since the tube was removed no *fæces* came by the wound. The removal of the crust just referred to, left a large skin-denuded surface on either side of the wound.

25th October (seventeenth day).—One-half of the abdominal surface was painted with liquefied gelatine, and a coating of melted paraffin. The side that was not painted bled very much. The patient slept better during the night. Bowels moved very often, and the evacuations were very offensive.

27th October (nineteenth day).—The patient complains of a fainting sensation and great soreness all over the abdomen, but on the whole feels pretty well. The gelatine came away in a cake owing to the continued discharge from the wound, the part which had been painted looking better than that which had not. The next day gelatine was placed on both sides of the wound, and was found to adhere better than at the last occasion. Patient now takes large quantities of milk and occasionally beef-tea.

This treatment gradually improved the local irritation very markedly and rapidly. The incision which at one time threatened, began to heal kindly throughout its entire extent, and by the end of November the irritated surface was perfectly healed. Latterly an application of boracic acid in glycerine was employed.

12th December, 1883.—At the present time the abdominal surface is completely free from rawness—the wound is entirely healed. There is neither abnormal distension nor abnormal dulness in any part of the abdomen. The abdomen, when percussed over the seat of the foetal sac, gives a perfectly resonant note. The bowels have gradually improved in their action from six times a day to thrice daily, twice daily, and for the last six days once a day only. The patient is putting on flesh and is getting up daily. She walks easily and feels gaining strength daily. I examined her per vaginam this afternoon, and I find now that all pelvic thickening is completely gone. The uterus is natural in size and quite moveable, and not a trace of any deposit or of tenderness can be felt per vaginam. Indeed, the patient gives now every promise of complete restoration to health.

The patient left the Infirmary on the 9th of January, 1884, in good health, with the exception of one day when castor oil was administered, on which there were three stools, the bowels have regularly moved once and only once daily since the 6th of December, 1883. The patient has gained rapidly in flesh and strength, and has been living on ordinary food including meat and fowl.

This would appear to have been a case of abdominal pregnancy which had settled in the right posterior part of the abdomen, and in which the child had lived till about the end of the sixth month. About the time the foetus died, inflammation took place in the sac. Considerable peri-

tonitis was produced with apparently thrombosis of the left iliac vein, and consequent dropsy of the left leg. Concomitantly with these there was absorption of the putrid materials contained in the sac, and the production of septicæmic symptoms, as indicated by the character of the breath and the temperature when she came into the hospital. This threatening state of matters was relieved greatly by the bursting of the sac into the bowel, and the subsequent free discharge of foetid pus per anum. Into the grounds of diagnosis in this case it is hardly worth while to enter, as these are only too plain. We had evidence of an enlarged uterus which was empty, and along with that a very complete history of the occurrence of pregnancy with foetal movements and milk secretion. As the foetus had died, we had no scruples in using the uterine sound to confirm our belief that the uterus was empty. Though the diagnosis was easy, yet the sequel has proved that the case of Mrs. S. is extremely interesting. The centre of importance in the case is its treatment. It may be doubted whether I was warranted in attempting to remove the bones of the foetus; and indeed, from my own experience of the alarming nature of the complications found, I would almost feel inclined, in another case to act upon the principle which was aptly put forward by Dr. Hart, when he came to see the patient the day after the operation, viz. : when there is any reason to fear communication between the sac and the intestinal canal, the moral of this case is to let well alone. Whilst I heartily said amen to Dr. Hart at that time, I am of opinion now that something has been added to our knowledge of what can be done by operation on the intestinal canal by the experience of this extraordinary case, and that though the general principle may be true, there is reason to expect not a few exceptions to it. No one present at the operation believed that the woman could live over twenty-four hours, yet to our surprise and delight she is now living and well, and nearly two months have elapsed since the operation. Besides what was I to do? The patient had been as above stated, nearly five months in hospital, and though she had improved very much, yet the slightest attempt at sitting up brought on attacks of pain that threatened to light up afresh all her peritoneal evils. I could not continue keeping the patient much longer in the house, and to send her out seemed consigning her to certain death. I

accordingly reluctantly resolved to operate. From the amount of suffering which the history of this case shows that the patient went through, I should not, I assure you, lightly subject another patient to the same ordeal. But I rather think that if a patient similarly situated were to present herself again in my clinique, I would feel warranted in the light of the experience gained by this operation, to give her a chance for her life by operating. It will be noticed that the foetal sac occupied the posterior and lateral aspects of the abdomen on the right, passing posteriorly behind the ascending colon, and anteriorly being closely connected with a loop of the small intestine, at least six inches long, which freely communicated with the sac, and, indeed, formed part of its wall, as we found it. This intestine was adherent to the abdominal wall; and it was on separating this adhesion by very gentle traction, believing it was the upper wall of the sac of the foetus, so as to get at the bones which I felt through it, that to my horror and dismay I found myself in the cavity of the intestine. It is idle now to discuss the question whether with greater care it would have been possible to avoid this lesion of the bowel. I simply may say I do not think so, if the operation was to be carried out at all. Having found myself in the unlucky predicament of having to deal with an opening involving six inches or so of intestinal canal, the walls of which were ragged, thickened, softened and almost gangrenous, with, in addition to that, a considerable fæcal fistula of another loop of small intestine, I did my best for the patient by cutting out the unhealthy torn piece and bringing together the raw healthy surfaces as accurately as possible, whilst at the same time I rawed the edges of the small fistula and brought them thoroughly together. This left a gap in the mesentery, which had also to be sewed up. As no operation of this sort was expected, we had made no special preparations for it and were only provided with good catgut. I acted chiefly upon Sir Spencer Well's experience, who, finding he had made a considerable cut into the colon in one of his operations, states that he brought the opposing surfaces together with a continuous catgut suture. This I did to the very best of my ability, taking care to bring out the needle on the one side and enter it on the other exactly at the edge of the mucous membrane, so as to avoid including any portion of the latter in the grip of the suture.

The stitches were also put very close together. The sequel shows that perfect coaptation must have been secured. I really do not know whence the small quantity of fæces came which was on several occasions observed previously to the removal of the drainage-tube. I am inclined to believe that it may have been from some fæces not reached by the sponge in our attempts at emptying the sac, or from a third sinus which had been unobserved, and which had been situated in the large intestine, as the quality of what was discharged was different from the milky-looking chyle which one sees in a case of a fistula of the small bowel. If so, the opening must have been small and must have spontaneously closed up as the other parts healed. Much advantage was derived, in the healing of the irritated surface, by the gelatine and paraffin dressing, which was suggested and carried out by Dr. Cockburn, to whom I owe thanks for his kindness in this connection. The distress from the raw abdominal surface caused by the stinking discharge was truly awful for some time. I have stated that this case appears to me in some points unique, and I still think so. This extraordinarily perfect recovery after resecting six or seven inches of bowel is very encouraging indeed, and ought to make us less frightened if in case of accident during abdominal operations, the intestines should unfortunately be injured.

Of course, resection of the upper end of the intestinal canal for cancer of the pylorus and stomach, etc., has been practised with more or less success by Billroth and other surgeons. But the cases that I have met with which came nearest to mine are two recorded by Professor Edward von Wahl, of the Dorpat Hospital in the *St. Petersburger Medicinische Wochenschrift*, and referred to in the *British Medical Journal* for May, 1883, p. 1015. These were, a case of resection in which two and a half inches of intestine were removed and the opposing ends brought together with a single row of catgut sutures, in order to cure an artificial anus. In this case the patient died on the third day from peritonitis, in consequence of two suture becoming loose. The part removed proved to be a portion of the transverse colon. The other case was one in which Professor Wahl, finding intimate adhesions between a dermoid cyst and the ascending colon, preferred to remove the portion of colon rather than separate it from the tumour. The

reason assigned is that the tumour was already, especially along the line of adhesion, undergoing malignant degeneration. In this case a double row of sutures were employed, one set embracing the mucous membrane and the muscular wall, and the other bringing the serous membranes into contact. This case did well for a month, and then went to the bad, apparently from malignant disease. It is clear in this case however, that the union of the bowel surfaces had been complete, a result which appears to me to have been essentially due to the increased number of stiches. But I will not weary you with any further remarks on this case. After the fact, I have several things to regret—1st. That I did not examine the exact state of the uterus and ovaries. 2nd. That I did not retain the excised portion of bowel. But this cannot now be helped and must be endured.

[For the above very interesting article we are indebted to Dr. H. Aubrey Husband, of Edinburgh.]—ED. LANCET.

CANCER OF THE RECTUM—OPERATION.

BY R. A. CORBETT M.D., PORT HOPE, ONT.

Mrs. H—aged forty-four years; resides in the Township of Hope; farmer's wife; mother of two children; always healthy up to present illness; family history good; no hereditary taint. First consulted me on February 5th 1883. Had been complaining since summer previous. Did not look unhealthy; was fairly nourished, but had become thinner lately.

Symptoms: a gnawing pain in the arms; aching pains across lower part of back, and shooting down right hip resembling sciatica; bowels irregular, but generally costive; passed blood occasionally; supposed she had bleeding piles. On examination I found an irregular tumor situated on the posterior part of the rectum, extending up about four inches, and the size of a goose egg. I decided to remove it, and on February the 19th, assisted by Dr. J. Might of Port Hope, the patient under the influence of chloroform, I removed the growth. It was easily broken up and looked like encephaloid cancer; there was not much hemorrhage. The wound healed rapidly; all pain ceased; her appetite increased, and she went home on the 22nd of March, very much improved in appearance. She

continued in fair health attending to her household duties until the latter part of July, when she returned to me, complaining of a little pain. On examination I found a small hard tumor just within the sphincter. The sphincter was rigid and unyielding and there was an enlarged gland in the right groin. I saw her again during the month of August and found the disease advancing rapidly, enlarged glands in both groins, pain across the back and down the right hips. I advised extirpation of the rectum. Before consenting she went to Toronto and consulted two surgeons. They declared the disease to be cancer, but objected to an operation, and told her to wash the parts with fluid extract of witch hazel, and further that there was nothing but to endure and die. On September 8th Dr. J. A. Mullin, of Hamilton, saw her in consultation, and agreed that her disease was without doubt cancer. During the months of September and October the pain in the right sciatic nerve had become excruciating and unremitting, the function of the parts increasing the suffering; no sleep obtained unless under the influence of narcotics. November 5th; the tumor had increased in size very much, involving the whole of the lower part of the bowel and extending upwards three inches. The sphincter was indurated, rigid, and unyielding; several small tumors had formed outside around the anus. She was tortured with pain, and urgently pleaded for an operation, saying she preferred death rather than endure such suffering. On November 15th, assisted by Dr. A. Hamilton, of Port Hope, the patient being under the influence of chloroform, I excised the whole circumference of the rectum, dissected the bowel up without difficulty for six inches, drew the gut down, and removed nearly four inches. I then attached the stump of the rectum to the skin, with six silver wire sutures. There was no hemorrhage of any consequence, and no vessels to tie. The wound healed in one week, except a little pocket between the bowel and vagina; removed all the sutures on the fifth day. The patient made a rapid recovery, and went home on the 18th of December. Before leaving she had fair control of the bowel, had gained in flesh and improved in appearance. The pain had entirely ceased, and she expressed herself as very much pleased with the result of the operation. February 7th, 1884; I had the opportunity of examining this patient, and found the rectum free from disease; the

glands in the groin about the same size; no pain. The patient sleeps well, feels strong and has gained very much in flesh; has fair control of bowel. There is one thing certain about this case and that is, if the operation does not prolong life, it has been the means of giving the patient great relief from her sufferings. I shall watch the result of this case with some interest.

THE TREATMENT OF ULCERS.

BY A. C. ANGUS, M.D., OXFORD, N. S.

To describe ulcers in all of their details, as to etiology, nosology, pathology, etc., would be to write a book, hence in this article I wish to confine myself solely to the treatment of ulcers.

Ulcers in years past (especially chronic ulcers) have been the opprobrium medicorum. In every community are to be found persons suffering from ulcers. In many cases these have been treated by various kinds of ointments, and finally after months and years of fruitless effort to cure them, the patient's have been told not to heal them for "as sure as you do, it will go to your lungs." I find it to be a popular notion that the cure of ulcers is detrimental to the health. As a result of these erroneous impressions there are persons who suffer from chronic ulcers for years, and even a lifetime without attempting to obtain relief. In standard works on surgery, ulcers are divided into various classes; but as all ulcers are merely so many forms of inflammation with solution of continuity of the soft parts, and with formation and destruction of normal elements, the most rational classification, it seems to me, that can be adopted is into *acute* and *chronic ulcers*. In order to give my method of treatment I shall describe one or two typical cases which I have met with in practice.

Case I.—Wm. B., aged 32, printer and mechanic. Saw him first on the 27th of August 1883. Upon enquiry I found the family history good. The ulcer was situated just above the ankle-joint. When first seen by me it presented the following appearance; ulcer extended half way around the leg; deep ragged edges; the surface covered with a quantity of pus; leg considerably swollen; edges of the ulcer extremely hard. As the patient was anæmic I ordered a mixture of iron and quinine followed by cod liver oil and

Fowler's solution. Locally I applied a poultice for twenty-four hours, then a solution of carbolic acid (1 to 35) to be used with an atomizer, the spray to be blown strongly under the edges of the ulcer, and all over its surface until thoroughly cleansed. No sponge or cloth should be used to cleanse the surface of an ulcer. The leg being very much swollen I applied tincture of iodine very freely until it was reduced to its natural size; also painted the surface of the ulcer a number of times with tincture of iodine which satisfactorily diminished the discharge. Subsequently I used a cloth oiled with vaseline and carbolic acid. The leg was kept perfectly at rest, elevated, and equable pressure maintained by means of a well-fitting elastic stocking. In one month the ulcer was entirely healed.

Case II.—Wm. A., aged 51, mechanic and farmer. Family history good. He had two chronic ulcers 5 by 3 inches, situated one on the outer, and the other on the inner side of the leg, lower third. Ulcers deep; edges callous and ragged; surface partly covered with pale unhealthy granulations, exuding a thin sanious pus. The leg was greatly swollen, and had a dark mottled appearance. The internal treatment was the same as in Case I. Also the same treatment locally with the exception of the use of iodoform ointment instead of tincture of iodine. One of the ulcers did not heal kindly. It progressed favorably for a time and then came to a stand still. I cauterized with solid nitrate of silver and applied a poultice for 24 hours after which I used iodoform ointment and then resumed former treatment. In less than six months from the commencement of treatment the ulcers were healed. The points which I wish to insist upon in the treatment of ulcers especially chronic, are these. 1.—Rest to the affected part. 2.—The use of the atomizer with an antiseptic solution to stimulate and cleanse, thus avoiding the breaking down of the weak granulations in dressing. 3.—The occasional use of strong stimulants to the surface of the ulcer. 4.—When practicable the use of well regulated pressure with elastic bandages. 5.—Such internal treatment as may be indicated. 6.—To quote from Westminster Shorter Catechism, "Perseverance therein to the end."

Selected Articles.

REMITTENT FEVER COMPLICATED WITH HÆMATURIA AND TYPHOID SYMPTOMS.

CLINIC BY PROF. TYSON, PHILADELPHIA.

Gentlemen,—In the case that I shall bring before you to-day there are some rather unusual features, which require study. The history is as follows: The patient, a labourer, 28 years of age, and a native of Ireland, was admitted to the hospital October 11th, 1883. He says that he has been temperate, and denies all venereal history. He was well up to the summer of last year, at which time he was working in New Jersey, and had malarial fever. This continued for two months. In September last he again had chills and fever. On the 1st of October he was exposed to the rain, and this exposure was followed by diarrhoea and a feeling of exhaustion. When admitted into the wards, the diarrhoea was slight, but he passed large quantities of dark-colored urine.

It is evident from this history that the man has had malarial fever; but the symptoms which he presented on admission were also of a kind to suggest typhoid fever. But, after watching the temperature and other features of the case for a few days, it became evident that this diagnosis could not hold. I wish to-day to call attention to the points in this case and discuss them with you, and draw such conclusions as may appear justified.

In the early part of the attack the patient had diarrhoea. When I first saw him, he had a dry, coated, leathery tongue. These, with a more or less constant feverish condition, are the suggestive symptoms alluded to; but careful examination of the abdomen failed to reveal the presence of the characteristic spots of typhoid fever. Even if this eruption, which usually appears about the eighth day, be not present, the temperature record will in ordinary cases enable the diagnosis to be made. The course of the temperature in typhoid fever is as follows: there is always an evening rise and a morning fall; but, as the temperature is recorded day after day, it is observed that the evening temperature is always a little higher than that of the previous evening, and each morning temperature a little higher than that of the previous morning: so that we have a tidal rise in the temperature, which, in the course of the second week, reaches its maximum. As the diagnosis in this case was not positive, the temperature was carefully taken twice a day. October 12th, a.m., it was 100.4°; p.m., 103.2°; 13th, a.m., 98.6°. This was altogether unexpected. Instead of being higher than the previous morning, it was two de-

gress lower. On the evening of the 13th the temperature was 100.6°, higher than the morning temperature, but still considerably less than the previous evening; 14th, a.m., 100°; p.m. 100.4°; 15th, a.m., 99°; p.m., 100.6°; 16th, a.m., 98.4°; p.m., 98.2°; 17th, a.m., 98.4°; p.m., 100.4°. It is not necessary to go further with the reading of the temperature. It is at least evident that there is nothing of the nature of a tidal rise. On the other hand, there is quite a constant morning temperature, which by evening has gone up to about 100°. It is clear that this is not a case of typhoid fever. There is another symptom in this case which does not belong to typhoid fever: there is more or less constant bloody urine. I can account for this condition on no other ground than that it is malarial in its origin. There is no undue frequency of micturition, and no evidence of disease of the bladder or of the kidneys.

The only conclusion to which I could come, in view of these facts, was that our patient's disease was essentially malarial fever of the remittent type, with typhoid symptoms, and might be called typho-malarial fever.

Now, there are two ways in which this term may be applied. In the first place, that disease may be called typho-malarial fever in which there is malarial fever complicated with typhoid symptoms, or the term may be applied to cases in which the two diseases exist together,—that is, typhoid fever running *pari passu* with malarial fever. A third application of the term typho-malarial fever has been made; that is to indicate a special form of fever with its own morbid anatomy, distinct from that of typhoid fever and of malarial fever. But this idea, which originated with Dr. Woodward, of the army, has been given up. Can we in this particular instance settle this question? Can we say whether it is a case of malarial fever with a typhoid complication, or whether it is a case in which typhoid and malarial fevers are concurrent? In the first place, there can be no doubt that two general diseases may coexist in the same individual. You have probably all heard of measles and scarlet fever running their course together. Some diseases are nearly always associated, as, for instance, pneumonia and pleurisy, and pneumonia and bronchitis; but I am now referring more particularly to general diseases.

There is, therefore, no reason why we should not have malarial fever and typhoid fever concurrent. But let us discuss somewhat further the grounds on which we conclude that such is not the case in the present instance. This patient has been under observation for twenty-one days. As a rule, a case of typhoid fever either becomes decidedly convalescent or else ends fatally by the end of the third week. In the course of the third week the temperature begins to fall, and there is a tidal decline. The morning temperature is a little

lower than that of the previous morning; the evening temperature a little higher than the temperature of the morning of the same day, but a little lower than that of the previous evening. If this were a case of typhoid fever, we should expect it to show some disposition to terminate. In point of fact, during the past week the symptoms have become aggravated. His dry tongue had, under the use of turpentine, become moist, and all the symptoms, excepting the hæmaturia, had improved; but last week they became aggravated, and the temperature rose decidedly. On October 24th and 25th the temperature was normal. On the 26th it began to rise, and reached 103°. The next day it was in the morning 103°, and in the evening 104°. Since then the temperature has not been below 100° until the evening of October 31st, when it was 98.4°.

These symptoms, however, suggest a relapse in typhoid fever. You are aware that relapses in this disease are not infrequent; but when typhoid fever relapses it repeats its previous history. The spots, diarrhoea, and peculiar temperature recur. But there has been no diarrhoea; there are no spots on the abdomen; there is no tympanitis; neither is there marked abdominal tenderness. This case does not give us a repetition of the symptoms of typhoid fever, and we cannot consider it a relapse. I feel constrained to class this as malarial fever of the remittent type; for, as you see, there is more or less continuous fever. There are also typhoid symptoms, so that in one sense of the term it is a case of typho-malarial fever; but it is not a case of concurrent typhoid and malarial fever.

As we were under the impression, when he was first admitted, that we had a case of typhoid fever to deal with, he was placed upon a treatment which would really answer for both diseases. In the first place, I always begin the treatment with quinine for a few days, for it is often impossible to tell at first whether a fever is malarial or typhoid. Sixteen grains of quinine per day, continued for four or five days, will have the effect, in the first place, of keeping up the powers of resistance of the patient, and, in the second place, will remove any malarial element. We used quinine in the present case, and the symptoms were much improved. On account of the condition of the tongue, I also ordered ten drops of turpentine four times in the twenty-four hours. We made no local application, as is our custom in typhoid fever, in the form of poultices and turpentine stupes. Under this treatment he improved decidedly. Last week we suspended the treatment, and in the result of this suspension of treatment we have another evidence of the malarial nature of the disease. As soon as the treatment was stopped, all the old symptoms returned. We again returned to quinine and turpentine; but during the past twenty-four hours the administration of these remedies has been interfered with by "hiccough."

The treatment of this symptom has therefore claimed our attention exclusively during this period. Sometimes it is a mere nervous symptom, which a more powerful nervous impression will cause to disappear. At other times it becomes a severe and obstinate complication. You all perhaps recall the treatment for the hiccough of our childhood,—that is, the taking of three swallows of water without interruption, which is the substitution of one nervous impression for another. Hiccough is a spasmodic contraction of the diaphragm, with a sudden closure of the larynx. A variety of remedies have been recommended: one of the best is counter-irritation in the region of the diaphragm. A large mustard plaster will often answer the purpose. If counter-irritation fails, morphia, in doses of one-quarter of a grain three or four times a day, may be employed. Failing in this, chloroform, in the form of the spirit or tincture, may be employed in doses of half a teaspoonful every three or four hours. Hoffman's anodyne is sometimes employed with advantage. Nitrite of amyl is also given with satisfactory results. In administering this remedy, the little glass pearls should always be used, one of them being crushed in a handkerchief and the drug inhaled. Another remedy which has considerable reputation in hiccough is musk. As it is doubtful whether we can now procure pure musk, it is not administered as often as it formerly was. Chloral in combination with bromide of potassium is an excellent remedy. The order in which, under ordinary circumstances, I would use these remedies is the following: counter-irritation with mustard, chloral, opium, chloroform, Hoffman's anodyne, musk, and finally a blister, as we have done in this case. The hiccough has been somewhat improved since the application of the blister. It is intermittent, lasting for a few hours, and then disappearing for several.

During the last few days there has been gradual improvement. The fever has diminished, and the amount of blood in the urine has lessened. This is a specimen of the urine last passed. From its appearance, only, it would be impossible to say whether or not it contains blood. A small quantity of blood in an acid urine gives the liquid a smoky hue, of which this is a fair representation. Sometimes the urine is perfectly clear. This is characteristic of malarial hæmaturia.

We have come to the conclusion that this is a case of remittent malarial fever with typhoid symptoms. As to the cause of these symptoms, it is difficult to say. He may be the subject of septic conditions resulting from his residence, habits, or other causes. Typhoid fever is a form of septic fever, resulting from the absorption into the blood of putrid poisons; but there may be other forms of manifestation of septic fever than the symptoms of typhoid fever. This man may have introduced

into his system septic matters giving rise to the symptoms which he has presented.—*Med. Times.*

SPONDYLITIS. CLINIC BY DR. SAYRE.

Gentlemen: This little child that I now present to you is suffering from spondylitis in the earliest stage.

The parents and other members of the family are perfectly healthy; and this child, beyond the difficulty of the spine, presents a remarkably robust appearance. I am informed that she commenced to complain of pain in her back and side, and of considerable difficulty in breathing, some six months ago, becoming restless, nervous, and irritable. Previous to this she had injured herself in falling from a chair. You will notice that there is a projection of the spine at the eleventh dorsal vertebra, and as she stoops down to pick anything up from the floor, she avoids bending the spine, but flexes the legs upon the thighs and the thighs upon the abdomen, thus squatting down and maintaining the spine in the erect position.

Now, as I lay the child upon her abdomen across my knees, the thighs and arms hanging down on either side, as you see, I slowly separate my knees, and in this manner make gradual traction, by this means extending the spinal column, and relieving the diseased surfaces of the vertebræ from pressure, and thus free the child from pain, and you observe the instantaneous change in her manner of breathing, from the short, quick, jerky respiration, to a deep, full, long inspiration, and the child seems perfectly comfortable. Now by drawing my legs closer together, you notice the immediate return of the previous spasmodic breathing; and now placing one of my hands upon her head, and the other upon her buttocks, and pressing the vertebral column together, she immediately begins to cry with the pain produced, and there is at the same time an instantaneous spasm produced in her legs. Now by gently separating my knees again, and extending the spine, the sobbing ceases, and she states that she is quite comfortable again. You now observe that I am making firm pressure over the spinous processes at the seat of the disease, and, according to all authorities, this should increase the pain; whereas, as you can plainly see, it does not do so. But, on the contrary, when slight extension is made upon the column, and direct pressure with your finger over the projecting spinous processes, there is rather a tendency to relieve the pain, by opening the angle of pressure in front of the vertebræ.

I have found that in these cases of antero-posterior curvature of the spine, by placing the child in this position, and gently pressing downward, at the same time making your traction as I have just described, you relieve the patient. The explanation,

to my mind, is simple enough, viz: by these two manipulations (the disease being situated in the anterior portion of the vertebræ), you relieve the inflamed surfaces from pressure, and, as it were, separate the anterior edges of the vertebræ from each other. This latter, of course, is an impossibility, but at the same time sufficient force is brought to bear by your combined manipulations *to relieve the diseased surfaces from pressure*, and hence the cessation of pain.

This examination we have now made will reveal the disease if it be in the anterior part of the bodies of the vertebræ; but there may be some cases in which the examination we have just made will reveal no evidences of disease at all, and at the same time there may be spondylitis existing. But by a more careful examination you will find the disease upon the side of the bodies of the vertebræ, and it has been caused by some blow or pressure upon the ribs, driving the heads of the ribs into their facets. You detect the disease in this position by pressing upon each rib separately, and the moment you come to the point of disease the patient will flinch with the pain induced by your pressure.

Having now made our diagnosis, I call your attention to the treatment of the case. I shall here apply the plaster-of-Paris jacket and *jury mast*: and will now show you the method of its application.

The child has already been thoroughly cleansed, and we put upon her a skin-fitting knitted wollen shirt tied over the shoulders, manufactured expressly for this purpose by the Bickford Knitting Co., 841 Broadway, this city. We now fold two towels and pass under the shirt in front, allowing them to extend the full length of the trunk. This is to prevent pressure upon the viscera, and allow of free respiration and expansion of the abdominal walls after eating; these towels being withdrawn as soon as the plaster has become sufficiently set. Having now adjusted the towels, the shirt is drawn down tightly and secured between the legs with a safety pin, and your patient is then ready for a partial suspension necessary during the application of the plaster-of-Paris jacket.

The child we now place in the suspending apparatus, which you will notice consists of an iron cross-bar with a chin collar of soft leather, and arm supports also. Having carefully adjusted this so that the weight of the body is borne evenly upon the arm-pieces under the axillæ and the chin collar which supports the head, we make gradual traction upon the vertebral column until our patient states that she is perfectly easy and free from all pain. In this case you will notice the traction necessary to secure this result, is sufficient to slightly raise the heels from the floor; in some cases this is not necessary, and again in others the traction required may be still greater; but never under any circum-

stances should your traction be so great as to lift your patient *completely from the ground*. This I desire you to specially understand, otherwise the word *suspension*, used in our description of the treatment, may lead you to suppose that the patient is to be literally suspended, when in reality it is but *partial suspension*.

This child then is fully prepared for the application of the jacket, and I will at once show you the manner in which it should be properly applied. You will here notice that I have from eight to twelve rolls of bandages formed of crinoline, into the meshes of which the dry plaster-of-Paris has been well rubbed and then rolled up moderately loose; not by any means as tightly as the ordinary roller bandage used in surgical dressings, but sufficiently tight to retain the plaster in the fabric, and at the same time allow of it becoming saturated to its centre rapidly when placed on the water. These bandages vary from two and a half to four inches in width, and also being from three to four yards long, depending upon the size of the patient.

I now place a roll of the bandage in a pail of tepid water, which is sufficiently deep to cover the bandage when standing upon its end, and then wait until it has become thoroughly saturated, which is shown by the cessation of the escape of air from the water. I again place another roll in the water, that it may become saturated while I am applying the one previously immersed. This one, as you observe, I now remove, and pressing out all surplus water, I carefully wind it around the waist of the child, my two assistants rubbing each layer of the bandage well into the preceding one. I would here call your attention to the manner in which I commence the application of the jacket, viz., at the waist, gradually going down until I come to just above the great trochanter. Then carefully reversing the bandages, as you see, I pass upwards again, and having secured sufficient thickness at the waist, I then pass on up the trunk, until I am on a line with the axillæ, and a little higher in front over the chest, and also higher over the scapulæ at the back. In some cases you find it necessary to put padding between the shirt and your plaster bandages, over the sacrum and crests of the ilii, and also *on either side* of the projection of the vertebræ where the disease is located, in order to prevent excoriation of these parts. But never put any padding *upon the projection of the vertebræ*, but place it upon either side, to prevent pressure upon that point. If you fail to do this and allow of pressure to be made there, it may result in a painful ulcer, which will delay your treatment many months; for if such an ulcer should be started the jacket must be at once removed and the patient placed in bed, until such time as it shall have healed, when the jacket may be again applied. I do not wish you to under-estimate the importance of this careful padding. It is not the plaster-of-

Paris that is going to effect a cure of this disease, but your skill in its application, and formation of a jacket by its use which will support and relieve the diseased surfaces from pressure, until such time as all morbid changes have been checked, and a healthy action set up in the hitherto diseased parts.

Now, in this case, although the disease is low down, I shall apply the *jury mast*. In some cases where the disease is so low down, I have omitted the jury mast, as its appearance is oftentimes objectionable. My friend, however, Prof. Samuel W. Gross, suggested that it be used in those cases in which the disease was low down as well as high up in the spinal column, and stated that he had secured much better results in its general application. I must heartily endorse his suggestion, and now apply it in almost every case of spondylitis.

You have observed that I have now shaped the lower portion of the *jury mast* to the back of the child, the lower part of the instrument consisting of these two iron strips which pass upon either side of the spine to the exact contour of the child, and it is now placed in the centre of the body, the bars running upon either side of the spine, the strips of perforated tin which you here see passing from the iron bands two-thirds around the body of the child. My assistant now retaining this firmly in position, the central rod running over the back of the head to the vertex, we again continue the application of the plaster bandages until the lower portion of the instrument is securely embodied in the jacket, my assistants, as you observe, rubbing each layer of the bandage into the preceding one.

You have now seen how simple the method and easy the application of the plaster-of-Paris jacket is. This child should now be laid upon an air bed, but as this is not at hand, we must substitute the ordinary hospital bed, and allow her to remain there until the plaster has become thoroughly set; it is then to be trimmed out under the arms and in front of the thighs, to allow of perfect flexion of the limbs; after which time the leathern collar which I here show you, is placed under the chin and occiput, then by means of these two straps on either side, which pass up, one over the inferior maxilla, and the other from the occiput to this small cross-bar attached to the central rod of the jury mast, our support is secured for the head and by means of which the entire weight of the head is removed from the spinal column if the straps of the head-rest be properly adjusted. You must, however, at all times be certain to get your central point of traction or suspension by means of this cross-bar at the end of the jury mast, immediately above the vertex of the head; leaving room at all times for a cap or hat to be worn upon the head under the instrument. At no time must the jury mast press upon the head; the distance desirable between the cross-bar and the top of the head is from three to four inches.

In removing the child from the suspension after the jacket has been applied, you must be extremely cautious that you do not allow her to bend her back before the plaster has set, otherwise your labor will have been lost. Also while applying the jacket, see that you carefully mould the jacket in above the crests of the ilii, so as to secure a shoulder for your jacket, but do not mould it in so severely as to cause pressure or excoriations.—
Medical and Surgical Reporter.

OBLIQUE CIRCULAR AMPUTATION.

BY JAMES HARDIE, M.D.ED., F.R.C.S., ENG.

The object I have in view in this short communication is to bring under your notice a method of amputating, by which the operation may be rendered as simple and expeditious as appears possible, and the correct principles of guidance be, at the same time, fully observed.

I will take it for granted that these principles include the following: 1. Due regard to the preservation of the length of the limb. 2. Ample cutaneous covering of the bone. 3. The location of the cicatrix out of the line of pressure. 4. Due regard to the nutritive supply of the stump, and the proper coaptation of the cut surfaces.

These conditions are, to some extent, antagonistic. For example: length of limb would be best secured by two equal sized flaps of skin only. But this would place the cicatrix directly under the end of the bone. Again, the nutrition of the stump would be best secured by including a large proportion of muscle, as in the ordinary flap-operation. But this would entail a higher division of the bone than skin-flaps, and difficulty would be experienced in accommodating the fleshy mass. To give all considerations their due weight, it would appear that a long flap of skin, with a quantity of muscle sloping from its base to a little distance from its free border, on one aspect, and a short flap of skin only, on the opposite aspect, would be the best method which could be devised. For obvious reasons, the long flap would generally be on the anterior aspect, and the short on the posterior. This is, practically, the operation Mr. Lister recommended, in his essay in Holmes's *Surgery*, for the thigh and leg. It is, of course, in these situations that full attention to the method of operating is chiefly demanded; and, though the principles are applicable to the upper extremity also, my present remarks have reference especially to the lower.

While fully agreeing, then, with Mr. Lister in the soundness of the principles which he advocates, I have yet constantly found, both in my own practice and that of others, that a certain degree of inconvenience is attached to this method of opera-

ting. In forming the posterior flap, the limb must be elevated considerably, and the surgeon has to cut somewhat awkwardly underneath it. In addition to this, considerable care has to be taken that the flaps bear a certain proportion to each other, in order that they may come together accurately. A certain amount of difficulty thus attends the operation, and it takes a somewhat longer time than one likes. Possibly, in consequence of these disadvantages, it does not appear to find that amount of favour which it otherwise merits; and certainly, judging from the number of stumps, both of the thigh and leg, which one meets with, showing a total disregard for the position of the cicatrix, and therefore for the future comfort of the patient, one would imagine that a ready method, by which the most important detail may be secured, is still a desideratum.

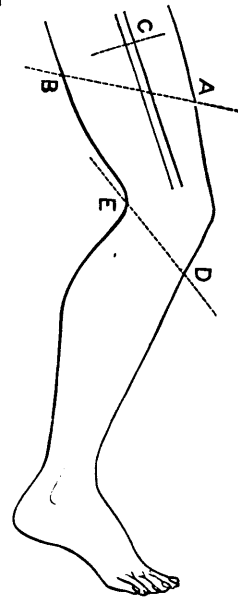
These considerations have led me to introduce into my own practice a different method of carrying out the objects which I have indicated. Bearing in mind the favour which the circular operation generally receives at the hands of operators, on account of the ease and rapidity with which it may be executed, it appeared to me that it might be so modified as to attain these objects in a very complete manner. I have, therefore, been accustomed to hold the knife obliquely to the axis of the limb, in making the sweep around it, instead of transversely, as in the ordinary operation. To take the middle of the thigh as an example, I place the heel of the knife at A, draw it round the limb obliquely, upwards and backwards, at an angle of about 55° to its axis, to B, where the direction changes, as it passes round the posterior aspect, to a direction obliquely downwards and forwards back again to A. Both at A and B, the line of incision is slightly rounded, so that A is convex and B concave. This incision goes at once down to the muscular aponeurosis; although it is convenient for the subsequent insertion of the stitches to have the skin free from fat midway between the upper and lower limits of the incision, on both the outer and inner side of the limb, as the flap has here to be folded on itself. The skin and its attached fat is next dissected back for a couple of inches at A, and taken in hand by an assistant, who pulls it upwards, so as to enable the surgeon similarly to separate it to a less extent all round the limb. This being done, the knife is then sunk obliquely into the anterior muscular mass, as was done by Alanson, until it reaches the bone; and the whole being well retracted, the remaining mass of muscles is totally divided in the ordinary manner by two principal strokes of the knife, the direction of which is still slightly oblique towards B. The bone being cleared, it is sawn at C, which is about an inch or an inch and a half above B.

As a result of this method of operating, the anterior portion of the soft parts falls well over the

face of the stump and end of the bone, the convex anterior flap fitting nicely into the concave posterior, and, when healing is completed, the scar is behind the bone, and in no danger of pressure. All the advantages of the method by long anterior and short posterior flaps are also preserved, and I believe it will be found that greater facility and expedition in operating are secured.

[A patient was exhibited in whom the operation was performed at the junction of the middle and lower thirds two years previously, and who was able to walk perfectly with the weight of his body resting principally on the end of the femur].

Amputation through the knee joint, with preservation of the patella by this method, I find to be a most excellent operation; excellent in the ease with which it is performed, and in the stump



which results. In this situation, owing to the distance to which the integuments of the ham retract after their division, it is advisable to draw the incision less obliquely than in the thigh, and my rule is to begin an inch and a half below the tubercle of the tibia, and to draw the knife round to a point about an inch below the cutaneous fold of the ham, D E. The skin and subcutaneous cellular tissue having been dissected up until the lower border of the patella is visible, an operation which is facilitated by flexing the knee, the ligamentum patellæ is divided, and the head of the tibia, with the semilunar cartilages, then separated by division of the other ligamentous structures. The assistant having then carefully drawn the posterior border of the incision out of harm's way, the whole of the structures behind the joint are next divided by a single stroke of the knife, from the surface inwards. With the exception of Syme's ankle-

joint amputation, I know of no operation which gives a better stump than this amputation through the knee; and I may remark, parenthetically, that I believe we should consult the prospects of recovery, and the future comfort of our patients, were we oftener to select amputation in this situation rather than in the upper third of the leg. [Two patients were exhibited showing this amputation].

In the leg, the incision may be drawn from before backwards and upwards, as in the thigh, special care being taken to slope the knife well upwards when dividing the sural muscles. Occasionally, on account of the tendency which the skin covering the inner surface of the tibia has to slough, I have taken the covering from the outside, retaining as much as possible of the muscular tissue attached to the fibula, and dividing the bones almost at the level of the incision on the inner aspect. The former method gives the better stump should no accident befall it, but the liability to sloughing is undoubted.

Although it is to amputation in the lower limb that I look upon this operation as specially applicable, yet I have also had recourse to it in the upper. Here, probably, the covering is best taken from the posterior aspect; and, in one case of amputation through the elbow-joint, I obtained an exceptionally good result in this manner.

I have practised this operation now for over ten years, under the name "oblique circular" amputation, as a term best describing its main feature. I am bound to confess, however, what I have not long since discovered, that an operation in all essentials the same has for long been described by French writers, as invented by Soupart of Liege. Though I cannot, therefore, introduce it to you as a new operation, yet I can cordially recommend it as an old one. I should have been glad, had I been able, to bring before you a greater number of persons on whom I have practised it; but, although I have only succeeded in tracing three whom I could bring to this meeting, I can frankly state that their stumps are not better than those which may generally be obtained.—*Brit. Med. Journal.*

INTESTINAL OBSTRUCTION.

The innate disposition of human beings to argue, the almost invincible desire of men to differ from one another, was never more clearly demonstrated than in the discussion of the important question of "Intestinal Obstruction" at the recent meeting of the British Medical Association. From the *British Med. Journal*, October 6, 1883, we note that the discussion was opened by Mr. Rush-ton Parker, the essence of whose address was that in all cases of intestinal obstruction, we should avoid all active treatment, and content ourselves

with merely watching the case carefully and noting any symptoms that may aid us to an accurate diagnosis, when our line of treatment becomes plain. The constitutional symptoms of intestinal obstruction are practically identical, no matter what the cause may be, and until some special sign calls our attention to the particular cause, Mr. Parker's expectant plan of treatment is clearly the rational one.

Suppose we have obstruction from invagination, or intussusception; we know that nature cures this condition by a process of gangrene of the incarcerated gut and union of the upper and lower segments of the unimplicated intestine; suppose now, before the union has become firm, or while the process of eating through of the invaginated gut is going on, we administer purgatives or enemas to remove the obstruction—will we not almost necessarily produce perforation, extravasation and death? Hence Mr. Parker's wise injunction: *When in doubt, use opium enough to control the pain, stimulants enough to keep up the strength, and avoid solid food*; if invagination be the trouble, this treatment will put the bowels in "splints," until nature restores the continuity of the canal; if it be not so, then no harm results from our treatment. But, on the other hand, if we can clearly make out the cause of obstruction, without excessive and likely to be injurious manipulation, and if it calls for surgical interference, as in strangulated hernia, adhesive bands binding down the gut, volvulus, carcinoma or some other tumor pressing on the bowel, Mr. Parker advised operation.

Several of the distinguished gentlemen present, catching only Mr. Parker's first part, or expectant plan of treatment, and either wilfully not hearing his wise regulations concerning the indications for operative interference, or actuated by a desire to hear themselves talk, roughly handled Mr. Parker. They assumed that he advised the "let-alone" treatment in all cases, and they censured him severely for it, indicating that operation was imperatively demanded in certain instances, and citing cases to sustain what they claimed, all of which Mr. Parker had already said. His views were probably a little more conservative than those held by some of his critics, for Mr. Lawson Tait held that it was wholly unnecessary and dangerous to wait for an accurate diagnosis, and he advocated early opening of the abdomen in the middle line, with the formation of an artificial anus in the first piece of distended intestine which presented. With all respect for this distinguished opinion we must think that the error of such precipitancy is evident; for should the obstruction prove a naturally curable one, as in many cases it would, we have not only subjected our patient to a dangerous operation, but we have afflicted him with a disgusting and inconvenient deformity. Again, by such a procedure, we are just as likely to open the gut

below as above the obstruction, and in such an event we are truly "out of the frying-pan into the fire."

It may be much more brilliant surgery, but it seems more in accord with the dictates of common sense and prudence to postpone surgical interference, either until diagnosis is sure, or until nature has demonstrated that, unaided, she is incapable of correcting the trouble. Billroth has set the example of bold and almost reckless surgery; and in these days of competition and overcrowding, he has plenty of disciples, anxious to gain notoriety by similar boldness; but the teachings of our really great masters, of nature and of experience, clearly indicate that the resort of the knife should be truly a "*dernier ressort*," and that it is always best to give nature a fair show. It is easy enough to *cut*, but it is sometimes extremely difficult to *heal*, and it behooves us to think twice before we cut once. There are certain clearly defined cases of diseased condition, where the knife is the only corrective, and "intestinal obstruction" is not one of them. We will better fulfill our noble mission, if we patiently watch and wait, until nature tells us in unmistakable terms that her opponent is too powerful for her great energies, and indicates clearly that she requires the assistance of the surgeon's knife, which we cheerfully admit in certain cases, such as tumors, constricting bands, and the like, she does.—*Med. and Surg. Reporter. Phila.*

CONGENITAL INGUINAL HERNIA, COMPLICATED WITH UNDESCENDED TESTICLE.

Dr. F. N. Otis related the following case in the New York Medical and Surgical Society (*N. Y. Med. Four.*): Not long since, a farmer, about thirty-five years old had been sent to him by Dr. Fanning, of Stony Brook, Long Island, complaining of great difficulty in wearing a truss for inguinal hernia. The trouble was found to result from the presence of an undescended testicle. He stated that, from infancy, there had been a slight swelling in the inguinal region. But little was done for it until he was twelve years old, when a physician discovered that it was a hernia, and, reducing it easily, applied a truss. This caused a good deal of pain, and it was then found, on closer examination, that there was only one testicle in the scrotum. The other one was discovered just below the external ring, and was movable, but it was not situated low enough, and could not be pushed up high enough to allow of the use of a truss without pain. The hernia was of considerable size.

When the man consulted Dr. Otis, November, 13, 1883, he was considerably reduced and had an expression denoting habitual suffering. He said he had tried various kind of trusses, but they all pro-

duced intolerable pain if worn continuously for more than a few hours. The hernia always protruded to the size of a hen's egg on the slightest departure from the horizontal position but it was readily reduced, the ring being very large. The testicle was found lying on the aponeurosis of the external oblique muscle, between it and the superficial fascia, and movable, from an apparent point of attachment at the border of the external ring, nearly three inches downward—to just within the scrotum, and upward to a point opposite the anterior superior spine of the ilium. It was somewhat atrophied, being about an inch by three quarters of an inch in its diameters, and quite sensitive on pressure. The patient was very desirous of having it removed and the hernial opening closed at the same operation. He had been married several years, and his only child was three years old.

Dr. Otis believed that the testicle was of little use, and that it would be entirely proper and safe to remove it, as it apparently had no direct connection with the peritonæum. He was not so much inclined to operate on the hernia at the same time, however, and he asked that Dr. Markoe be called in consultation. Dr. Markoe agreed with him entirely. Rather more than three weeks ago he removed the testicle. It was pushed up as high as possible, and outward toward the border of the ilium. On cutting through the skin and the superficial fascia, the testicle protruded with its coverings. The cord was readily drawn out to the extent of about two inches and a half, and was secured while excision was performed. The vessels, evidently considerably atrophied, were then tied. There was but little hæmorrhage. The wound was sponged with a solution of bichloride of mercury (1 to 1,000), and a carbolized-gauze compress and a spica bandage were applied. The patient had been subject to attacks of vomiting at times, and on such occasions he had been unable to retain the hernia within the abdomen by any means. He vomited a good deal after coming out from the effects of the ether, considerable pain was complained of, and, on removing the bandages, the hernia was found to have descended. It was easily reduced, the compress was replaced, and the patient did well.

PLASTER DRESSING FOR MOVEABLE FRACTURES.

I have read with much interest the concise and instructive article by Prof. Walker, of Detroit, on the use of plaster-of-paris as a dressing for surgical purposes. In a conversation with my friend, Prof. Dawson, of Cincinnati, last summer, he described to me a dressing for fractures occurring at or near the shoulder joint, in which the plaster on strips of muslin of variable lengths, was laid on and over the injured part, strip at a time, making a dressing

absolutely immovable and highly satisfactory in every way. I was called to assist Dr. Judkins, of this place, in dressing a fracture of the humerus, about one inch from the shoulder joint, in a man strong and muscular, æt. 60. The man had fallen from a tree, striking on the palm of the hand, breaking the bone as above, and driving the upper end of the lower fragment forward and upward, tearing the soft parts, and almost coming through the skin below the clavicle. Owing to the severity of the injury, a simple dressing was applied, and evaporating lotions used, after the fracture had been reduced under chloroform. In a week or ten days we put the plaster dressing on, as above described: 1st. Bandaging the arm and shoulder carefully and smoothly. 2nd. Cutting a bandage into short strips, one inch wide, and from four to twelve inches long. Then with the plaster made thin, and to which a small part of potas. sulph. had been added, each piece of the bandage was saturated and carefully laid on over the bandage already on the shoulder. By such means a complete mould was made of the arm and of the scapular and clavicular regions. When the plaster had set, the bandage first put on was cut up on the inner side of the arm and across the shoulder above, and the cast removed. The edges trimmed, the splint was well padded with cotton, re-applied to the shoulder and retained by a roller. I am well pleased with the dressing and the result in this case. The parts were held firmly, quietly and immovably, the dressing was cool, did not cut or bind at any point, a fault so common in all other dressings for fractures in this region. It could be removed and re-applied with ease, and without moving the arm in any degree. In cases of injury at the shoulder it seems to me this form of dressing has marked advantages over any other dressing that can be applied. And for immediate application it would not be open to the objections urged against the plaster dressing applied by the simple roller. But any fracture can be dressed in the same manner, and where there are irregular surfaces, I do not think any other form of plaster will compare with it. One thing should be borne in mind, the strips being laid on one at a time, do not require to be heavily coated with plaster. Unless attention is paid to this the cast will be unpleasantly heavy.—*Med. Age.*

ANTISEPTICS IN GERMANY.—Dr. Lardy, on a visit to Germany, in a letter to the *Union Médicale* (December 27), furnishes some information with respect to the antiseptics now most in vogue in that country. The somewhat exorbitant prices of the Listerian dressings, and the search after a perfect antiseptic have, he says, not a little modified the practice of surgeons of late. The employment of spray is more and more abandoned, and is now

only resorted to for the purpose of disinfecting the theatre before the operation. It is disadvantageously replaced by the frequent washing of the hands in a disinfecting solution, and by the more or less continuous irrigation of the wound and its vicinity by a 1 or 2 per cent. carbolic solution, solution of corrosive sublimate, etc., etc. The enthusiasm for carbolic acid has much abated, and in many universities its solution is only employed for the disinfecting of instruments, because it does not damage these. For other purposes that excellent disinfectant corrosive sublimate is preferred for its cheapness, and for the rapidity with which very weak solutions destroy the very spores of infecting organisms. The solutions most generally employed are 1 per 1,000 for infected wounds, 2 per 1,000 in ordinary cases, 1 per 5,000 for irrigation during the operation, and 1 per 10,000 in laparotomies, in which the object is direct injection of the peritoneal cavity. The results are excellent. In a certain proportion of cases some absorption of the agent is indicated by a slight elevation of temperature for two or three days at most, but this is very rare. The secretion of the wound is not abundant under the sublimate, and good healing by first intention is obtained. The solution of this disinfectant has also the great advantage of not rendering the skin of the hands so rough as carbolic acid. *Chloride of zinc*, much recommended by Kocher, of Bern, also furnishes good results in a solution of 2 per 1,000, and is especially employed in washing out the peritoneal and pleural cavities, presenting as it does little danger of absorption. It is curious that Koch, of Berlin, should still deny its antiseptic value, for experience shows that he is absolutely wrong. More recently, Prof. Kocher has proposed the *subnitrate of bismuth*, the disinfecting power of which would seem to be more potent than that of iodoform, while it is exempt from the danger of the latter. For the irrigation of wounds a solution of 1 or 2 per 1,000. It may also be employed in powder, or a bismuth gauze of from 10 to 20 per cent. is easily made. Prof. Socin, of Bâle, has recently proposed *oxide of zinc*, which is preferable to bismuth only when more concentrated solutions are required. These two last antiseptics are also employed in the form of a paste, in order to close in hermetic fashion wounds recently sutured, and with bismuth used in this way splendid cicatrization by the first intention may be obtained. Last summer, a mixture of sugar and naphthalin was used at the Strasburg Clinic, and Prof. Lucke, a great admirer of popular remedies, was full of enthusiasm for the new treatment. Iodine-water, thymol, and salicylic acid may be mentioned, although their employment has not become generalised; but, on the other hand, concentrated *tincture of iodine* has attained more favour as an energetic disinfectant in septic wounds, the cavi-

ties of abscesses and mortified and fetid soft parts. Iodoform is employed now more in France than in Germany, where fear of intoxication prevails. It is especially in favour, like naphthalin, for small dressings at the dispensaries. For dressing wounds successive layers of bismuth paste are applied, which are covered by simple gauze that had been previously soaked for some hours or some days in a solution of carbolic acid, sublimate, or bismuth—squeezing out the liquid at the time of application. This gauze costs infinitely less than that of Lister and analogous gauzes, and furnishes quite as good results. The protective and caoutchouc have also fallen into desuetude, and the wadding is replaced by the most various materials. Nearly every clinic has its own procedure, from carbolised jute to turf, moss, sand, ashes, sawdust or powdered glass; marsh-turf, moss and sawdust are washed in abundance of water, dried and roasted at a temperature of from 100° to 100° C., and disinfected in a sublimate solution of 1 or 2 per cent. They are then dried, put into bags, and placed over the dressing in the same way as wadding.—*Med. Times and Gazette.*

A NEW METHOD OF APPLYING PRESSURE TO ENLARGED TESTICLES.—Dr. J. L. Corbett of Lucknow, writes in the *Lancet*: In the treatment of some of the diseases of the testicle, accompanied with enlargement, the practice of applying pressure to the gland is undoubtedly a sound one, and is frequently resorted to by surgeons. I have often wondered that some simpler plan than that of strapping with plaster has not been suggested. The objections against the plaster strapping are numerous. First it is a tedious business to do neatly and properly. Second, it is dirty, both for operator and patient. Third, the operation has to be begun by encircling the neck of the gland with a long strip of plaster. This undoubtedly interferes with the free circulation in the vessels of the cord, and tends to prevent the absorption of the material deposited in the gland. It stands to reason that the freer the circulation in the vessels going to or from the testicle, the more rapid will the reduction in size be from the operation of absorption induced by pressure. Fourth, the strapping loosens very rapidly, and, to be of use, must be reapplied frequently. Fifth, in many cases, even when carefully applied, the plaster cuts the skin and leads to sores. Sixth, I have seen nasty, troublesome eruptions on the skin of the scrotum, following the use of the plaster. I have, I think, enumerated enough objections to the old plan; and I will now try to explain the means I would recommend for obviating these objections, at the same time applying a steady, equable compressing force, and one which would also admit of easy regulation as regards the amount of compression. I may preface the explanation of my plan

by saying that I derived the idea from a homely source—nothing more nor less than seeing the means employed for encasing a football; barring that, instead of having the encasing material made of leather, I would have it made of India-rubber—such as one sees in the construction of the balls in spray-producers, etc. The cases I recommend should be made of different sizes, many thicknesses, oval in shape (same shape as the Rugby football when inflated). The means of tightening the cases and applying the pressure would be identically the same as the football cover—i. e., by lacing. There should be an opening at the neck of the case to allow the passage of the cord. This opening would be surrounded by a ring (interrupted) of leaden wire to insure its patency and to prevent pressure on the structures of the cord. The leaden wire ring being interrupted, its softness would offer no obstacle to its adjustment round the neck of the enlarged gland. With a supply of the cases which I have attempted to describe above, the treatment of an enlarged testicle would offer but little difficulty: it would simply mean the selection of a rubber case of the right size and thickness, and capable, when laced up, of exercising a steady, equable pressure on the enlarged organ, and applying the case to the testicle and lacing it up. If considered necessary, the testicle could first be enveloped in a thin layer of cotton-wool: this would prevent any possibility of the skin being nipped or chafed by the lacing. As the gland reduces in size, a smaller case would be applied, and thus a steady pressure kept up until a cure was effected. The above plan has the advantage of simplicity, neatness, and quickness in its application, to recommend it. It involves no elaborate apparatus, and I think does away with many, if not all, of the objections connected with the operation of strapping with the plaster.—*N. Y. Med. Jour.*

PAROVARIAN CYSTS.—Dr. Goodell exhibited two cysts of the parovarium before the Obstetrical Society of Philadelphia (*Medical and Surgical Reporter*, January 5th). Both patients got well; he indeed had never lost a patient from whom he had removed a parovarian cyst. In both cases a correct diagnosis was made previous to the operation. Regarding the differences between this tumor and the cyst of the ovary, he remarked that one interesting diagnostic point was the complete absence of the *facies ovariana*. The color in the cheeks was good, and the countenance was free from the anxious expression present in cases of ovarian tumor. One tumor had existed for ten years, the other for one. Another important point in the differential diagnosis is not only the flaccidity of the tumor but its variable degrees of flaccidity. Upon inspection, it is seen to reach to the sternum, and seems to occupy a large portion of

the abdominal cavity, but when the hands are placed upon its sternal edge it can be compressed to the level of the umbilicus. An ovarian cyst, on the contrary, is hard and uncompressible. Exceptions to this rule are very rare, that is, either a tense parovarian cyst or a flaccid ovarian one. A third important distinguishing point is the long time—ten years in one case—which the tumor existed, and further, without marked deterioration of health. After being tapped these tumors usually refill, but occasionally they do not, and a cure is thus brought about. The fluid withdrawn has been in every case limpid and generally colorless, but it has sometimes had in his experience an emerald tint. These tumors are generally free from serious adhesions, but if, in an operation for the removal of one, adhesions should exist where for any reason their forcible separation would be unadvisable, or the cyst were intra-ligamentous, he would not hesitate to leave the adherent portion of the cyst wall, or the whole cyst itself, after making a big hole in it, as the fluid it secretes is bland and unirritating to the peritonæum.

Any one examining one of these cysts for the first time would consider it to be of ovarian origin, for it is only by patient search that the ovary can be found spread out over the cyst wall. The microscope will decide with certainty in any otherwise doubtful case. The tumor is covered with a beautiful net-work of veins.

When a cyst of the parovarium exists on one side, the ovary of the opposite side is usually found to be diseased and should be removed. In these cases the remaining ovary was seen to be enlarged, and the site of a small ruptured cyst was pointed out. The Fallopian tube was also enlarged, and the terminal vesicle of the Fallopian tube, or the hydatid of Morgagni, was enlarged and cystic. This hydatid sometimes attains the size of an orange, and often ruptures spontaneously without any bad effects. A few years ago one of these small cysts ruptured while he was making an examination of the patient to ascertain its character.

A RENAL FORM OF TYPHOID FEVER.—Dr. Didion has chosen this subject for an inaugural dissertation, and comes to the following conclusions: Typhoid fever produces a renal congestion, which plays an important part in the course of the disease. Albuminuria is almost constant, but generally slight and temporary; when abundant, it is a sign of true nephritis. The real inflammation is both parenchymatous and interstitial, and produces certain characteristic symptoms, such as asthma, stupor, dryness of tongue, œdema of the face and legs, lumbar pains, cutaneous eruptions (pemphigus, ecthyma, boils), and an alteration of the urine, which has a reddish color and the odor of boiled bread: to the deposit, red and white blood-corpuscles are found, as well as casts; the

urine contains a large quantity of albumen. The diagnosis can easily be arrived at by the above-mentioned symptoms. The termination is often fatal, either from asthenia or uræmia. As to the treatment Bouchard recommends carbolic acid and the salicylates, Polli the sulphites, Klebs the benzoate of potash. Leeches, mustard poultices, and cupping in the lumbar region are useful; but blisters even with the addition of camphor, must be avoided. In certain cases the disappearance of the symptoms is accompanied by abundant diuresis, which ought therefore, to be favored if possible; but all diuretics are not equally good, those which possess irritating properties must be avoided. The best in these cases is milk, pure or mixed with water. Whatever may be the way in which it acts on the kidneys, it is always well borne and its action is double; it increases the secretion of urine, and hastens the elimination of toxic principles, without producing any irritation, even in the most acutely inflamed kidney. Subcutaneous injection of pilocarpine might perhaps be useful; in one case when the skin was dry and burning hot, Dr. Didion injected twice daily one-sixth of a grain of pilocarpine, and under its influence the skin became moist and abundant sweat was produced; the tongue also was less dry than before; the temperature fell in two days from 105.8° to 98.6° F.; but three days later the patient died, after the temperature had once again reached 104° F. New investigations are necessary before we can arrive at definite conclusions. As for the cold baths, Gubler thinks that they are contra-indicated in case of nephritis, but Libermann considers their use as surely beneficial in spite of it. Several patients who had been subjected to that treatment did not complain of any inconvenience, and cold lotions rapidly applied to the trunk and limbs with a sponge seemed to relieve the patient, lower the temperature, and re-establish the functions of the skin. All these advantages must be weighed against the danger of a renal congestion; but further experience alone can show which treatment is most advantageous.—*British Medical Journal*.

THE SINGLE SUTURE IN LACERATED PERINEUM.—Dr. T. Johnson Alloway, of Montreal, in an article on this subject in the *Am. Jour. of Obstetrics*, January, 1884, concludes as follows:

1. Examine carefully, *with your eyes*, every perineum after removal of placenta. If lacerated to more than a quarter of an inch, apply the suture.

2. Use one of Emmet's long, straight perineum needles, with a silk suture. By the aid of a holder, force the needle through the skin on the left side of the tear, half an inch from its edge, at any point between the beginning and end of tear, but the nearer to the beginning, that is, the higher up, the better will be the result. Now,

with the two fingers of left hand in the rectum, press up the rectal wall and recto-vaginal cellular tissue, so that the needle can be rapidly, though steadily, made to glide beneath this tissue and over the rectum, hugging the latter as closely as possible to make its exit at a corresponding point on the opposite, or right side. In tying the suture, avoid doing so too tight, as it is a good plan to allow for swelling, which generally lasts for some days.

3. Be sure that the needle in no part of its course makes an exit in the vaginal surface; if so, you will probably have a pus pocket.

4. The operation is very simple, and can be performed by any physician of ordinary experience.

5. The after-treatment consists in washing out the vaginal passage night and morning with any antiseptic solution the physician is accustomed to use. *But he must do it himself*; the nurse would be as likely to pass the tube below as above the suture, *and kill all your joy*. As regards antiseptics, I use in such cases a solution of corrosive sublimate $\frac{x}{\text{ss}}$ once in twenty-four hours, administered at night. I find this solution as handy and harmless as carbolic acid. Tell your chemist to make a ʒij alcoholic solution of hyd. bichl., each drachm of the solution to contain seven and one-half grains of the salt. One teaspoonful of this mixture added to a pint of water will give, almost to a fraction, one part in one thousand. I have used this solution in cases of metria three times in the twelve hours for two consecutive days without any evidence of toxic effects from absorption. It is probably due to the formation of an insoluble albuminate of mercury, which seals up all breaks in the surface for a time.

6. The suture had better be allowed to remain in situ for nine or ten days. I am strongly in favour of the silk; the wire suture is liable to produce a bleeding point or two on removing it. This accident might prove troublesome from absorption, which is so active at this period of convalescence.

7. The nurse is the only assistant you will require, and is, of course, in your confidence.

HIGH AMPUTATION FOR SENILE GANGRENE.—Mr. Jonathan Hutchinson read a paper on this subject before the Royal Med. and Chir. Society of London, of which the following is a resume: (*Lancet*). It began with the statement that the author's chief object was to urge the safety and expediency of amputating in senile gangrene if the operation were done at a great distance from the disease. In the common form of gangrene of the toes and foot, the lower third of the thigh was the part suggested as the proper level of the amputation, and in rarer cases in which the hand was affected, the middle of the upper arm. After remarking on the fact that amputation had hitherto generally proved disappointing owing to return of

the disease, the author urged that this was owing to their having usually been done too low down. The calcification of the arteries upon which, in the main, the disease depended, was usually greatest near the periphery, and hence the difficulty as to supply of blood for the nutrition of the flaps. This source of danger was not met with if the amputation be done sufficiently high. In a series of cases, in very old patients, the author had not encountered the recurrence of gangrene excepting in one. In three the stump had healed well. In a fourth, in which the patient, although not old, was prematurely senile and the calcification of the arteries extreme, the recovery had also been excellent. In this instance the femoral artery was so rigid that it stuck out from the face of the stump like a small bone. One of the patients, in whom the stump had healed without a drawback, was seventy years old. In two of the cases the other foot had been subsequently threatened with gangrene. As to the time to be selected, the author thought that as soon as the patient was so ill as to be confined to bed and the disease was well established, it was best to operate. Spontaneous cure was, he urged, very exceptional, and a great majority of such cases ended in death after a long period of much suffering. The thinner the patient the less was the risk of the amputation. In a few cases in which the thigh was exceptionally fat and the tissue flabby, it might be wise to hesitate as to recommending it. In all cases Lister's precautions had been carefully used, and in two or three the patient had never experienced the slightest pain from the day of the operation.

EXTRA-PERITONEAL PERI-UTERINE HÆMATOMA.

—A recent number of the *Zeitschrift für Geburtshülfe und Gynäkologie* contains a long article bearing the above title, by Dr. A. Martin, of Berlin. This author believes that cases of the kind which the title denotes, present characters distinct enough for their separate identification. He describes four cases, in which the nature and exact seat of the disease were made certain by operative exploration. He quotes three other cases, in one of which the same diagnosis was established by operation, and in two by autopsy. From this basis, he gives the following as the characteristic features of this form of disease. First, the local signs. The uterus is very definitely displaced laterally, and generally pushed forward as well. The tumour formed by the effusion is not in the middle line, but occupies one side only of the pelvis, so that on the opposite side the examining finger detects no abnormal signs. On examination per rectum, the lateral position of the tumour can be made out with precision, and when the posterior surface of the uterus is explored with the finger, it can be ascertained that the effusion is not situated between the uterus and the rectum;

in other words, that Douglas's pouch is empty. Next, the symptoms. The commencement of the illness is sudden, and marked by abdominal pain, hæmorrhage, and signs of collapse: but the symptoms characteristic of peritonitis—vomiting, distension of the belly, pyrexia—are absent. Believing that he has thus established the diagnostic signs and symptoms of this form of disease, Dr. Martin proceeds to apply his generalizations to other cases, in which the diagnosis has not been made clear by post-mortem examination, or operative exploration. He has collected from literature eleven such, and from these, together with the verified cases before mentioned, he proceeds to describe the etiology, pathogenesis, anatomy, symptomatology, differential diagnosis, prognosis, and treatment of the disease. It seems to us that all our author has to say, that is at once important and novel, is based upon the cases in which the diagnosis was established beyond doubt; and therefore we refrain from further epitome. We may mention, however, that he regards the diagnosis between an old extra-peritoneal hæmatoma and a subserous fibroid, in the absence of a reliable history, to be quite impossible.—*Med. Times and Gazette.*

DISLOCATION OF THE TENDON OF THE BICEPS.

—In *The American Journal of the Medical Sciences* for January, 1884, Dr. J. William White reports a case of this form of luxation, and reviews the history of other cases of the same nature. The symptoms in Dr. White's case, which led him to the conviction that there had been true traumatic luxation of the bicipital tendon, may be enumerated as follows:

1. The recognition of the bicipital groove, empty, which, if its existence be admitted, is pathognomonic.
2. Recognition of the tendon itself.
3. The inward rotation of the arm.
4. A slight depression under the tip of the acromion, a prominence of the shoulder in front, and a flattening behind.
5. Diminution in the vertical circumference of the shoulder.
6. Shortening of the arm as measured from the tip of the acromion to the external condyle.
7. Elevation of the shoulder, tilting up of acromion, and elongation and narrowing of axilla when the arm was carried upwards.
8. The peculiar depression situated over the bicipital groove.
9. The line of ecchymosis following and strictly limited to the course of the biceps muscle.
10. A creak or "squeak," heard distinctly on carrying the elbow away from the side.
11. Flexion of the forearm on the arm was painful, the pain being sharp, lancinating, and felt at the front of the shoulder; flexion during supina-

tion was much more painful than flexion during pronation.

12. When extension of the forearm was attempted, a tense line along the edge of the biceps could be both felt and seen.

13. The pain felt over the joint was also felt along the line of the biceps as far as its insertion, and the patient still has a "drawing" sensation over that region.

14. The arm was preternaturally mobile for some time after the accident.

15. The position of the patient after the accident.

16. The character of the force producing the difficulty.

The rationale of these symptoms is very fully explained.

NOTE ON HYOSCYAMINE.—Dr. R. A. Hayes, of Dublin, Ireland, reports (*Dublin Journal of Medical Science*, December, 1883) a case of tremor of the left arm which he treated with hyoscyamine. The patient, when he came under Dr. Hayes' care, had been troubled with this tremor for six months. Eighteen months before it came on he had suffered an injury of the shoulder of the same side. He was given one sixteenth of a grain of hyoscyamine in pill. A single dose daily for two days produced no effect on the tremor. Next day two doses, morning and evening, relieved the tremor in some measure. The following morning a dose of one eighth of a grain was given. Delirium soon supervened, and continued through the day, but the tremor ceased. The next morning one sixteenth of a grain was followed by delirium, which did not completely pass off until the following day; but the tremor was decidedly controlled. The drug was now discontinued, it having completely paralyzed the patient's accommodation and interfered seriously with his sleep. The tremor returned at once, and soon became very marked. Three days afterward the hyoscyamine was resumed in doses of one thirty-second of a grain three times a day. In two days the tremor was lessened; in six days the ciliary muscle had again become paralyzed, and the medicine was stopped at the patient's request, though the tremor was much relieved. The smaller doses, while they did not effect the pupils, paralyzed the accommodation so completely that reading was impossible. It should be stated, however, that, when the administration of hyoscyamine was begun, the patient's eyes had not recovered from the effects of atropine, which had been used to facilitate an ophthalmoscopic examination.—*N. Y. Med. Jour.*

TO ABORT MAMMARY ABSCESSSES.—In the *Lancet*, for Dec. 15, 1883, will be found an article by Dr. James Braithwaite, in which he says: "In cases of threatened mammary abscess, I have for

many years, with very successful results, given three consecutive doses of ten grains of quinine at intervals of twelve hours, at the same time using the usual local application of belladonna. The administration of quinine in these cases, although its anti-suppurative power is well known, is not practiced by any one with whom I have conversed, but I have myself found it so successful, that I think it deserves to be in general use, especially as the disease is so painful and so exhausting to the system. The best cases for the treatment are those occurring during lactation, and it is less suitable immediately after labor. It is unsuitable if the bowels are confined and the tongue furred. There are some patients who do not bear such large doses of quinine, in which case a first dose of ten grains may be followed by two of five grains each. I originally saw this treatment recommended in a French medical journal, and claim therefore no originality. I have frequently seen the pain and tenderness disappear within forty-eight hours although a little hardness will remain for some days or longer, and the inflammatory symptoms may recur, and may be again at once checked by the same treatment. A recurrence, however, is rendered less likely if the belladonna is continued for a time, although pain has ceased. No doubt some will say that the success of the treatment is owing to the belladonna, and not to the quinine. I used the belladonna for years before I used the quinine in addition, and was struck with the greater rapidity and certainty of the result when the quinine also was used. At the same time I admit the difficulty, when two drugs are employed, of apportioning to each its real value."

TREATMENT OF ECZEMA OF THE GENITALIA.—In cases of eczema, in which glyceroles and unguents have failed, the following formula has been successful.

R Chlorate of potassium, grs. xxx,
Wine of opium, grs. l,
Pure water, Oij.

Applied to the parts by linen compresses covered with oiled silk. If there is much inflammation, precede this with warm hip-baths and cataplasms sprinkled with powdered carbonate of lime. Is obstinate pruritus, associated with leucorrhœa, a tablespoonful of a mixture of equal parts of tincture of iodine and iodide of potassium, in a quart of warm tar water (tar-water holding the iodine in solution), used daily, night and morning, removes the pruritus and ameliorates the leucorrhœa. In fetid leucorrhœa, two or three tablespoonfuls (in a quart of warm water, morning and evening, as an injection) of the following formula will be found useful.

R Chlorate of potassium, parts xij,
Wine of opium, parts x,
Tar-water, parts ccc,

Or,

White vinegar (or wine), parts ccc,
Tinct. eucalyptus, parts XLV,
Acid salicylic, part j,
Salicylate of sodium, parts xx.

One to five teaspoonfuls in a quart of warm water, as an injection, two or three times a day.—*Obstetric Gazette*:

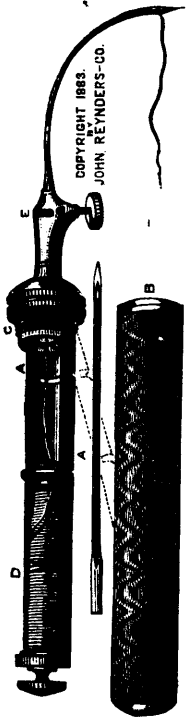
TREATMENT OF VARICOSE VEINS.—Mr. Folker describes, in the *British Medical Journal*, a recent operation he performed for the cure of varicose veins. In the operation the vein was securely tied, and ultimately obliterated, without any disturbance of the surrounding parts. The man was operated upon on Saturday, and the following Tuesday week (eleven days) he was up in the ward. The operation was as follows: A small incision was made on each side of the vein, and a curved needle, passing in at one incision and out at the other, carried the ligature under the vein, and was withdrawn. A flat instrument was now in the same manner, passed in at one and out at the other incision, and threaded with one end of the ligature, which then, by its withdrawal, passed the ligature over the vein. The two ends of the ligature, which now surrounded the vein, projected through one opening. This was repeated in as many places as might require it, and then the lowest one was tied first, and the ligature cut off close, firm pressure was made over it just to press out any drop of blood that might be present, and the little opening was closed with collodion. Each ligature from below upward was tied in a similar way, pressing the blood out of the vein up to each ligature before tying it. The ligature used in the present case was pure silk, well carbolized; but Mr. Folker hoped to tie some with tendon ligatures which would become thoroughly absorbed sooner than the silk.—*Low. Med. News*.

USE OF COLLODION.—Mr. Sampson Gamgee, *Birmingham Medical Review*, says: To swollen parts which can not well be bandaged, collodion is especially applicable for the compression attending its contraction. I was lately consulted in the case of a good looking boy considerably disfigured by a red and swollen nose, which became very pale and visibly contracted just after I painted it with successive layers of collodion. I repeated the application three times in the succeeding fortnight, with the effect of producing shrinkage of the organ to its natural size and color.

When the nasal bones are fractured, a very effective mould for keeping them immovable, after adjusting them with the fingers, may be thus made: place over the nose a thin layer of absorbent cotton soaked in collodion; as it dries another layer of cotton and more collodion, taking care that the application extends sufficiently on each side to

give a buttress-like support. The patient compares the feeling to the application of a firm bandage on the nose, and the bones consolidate effectively under the shield, which may be renewed as it cracks and peels off.

GOETZ'S SUTURE INSTRUMENT WITH ENDLESS THREAD.—This instrument combines in one needle, needle holder, ligature thread and disinfector. It consists of a hollow cylindrical part,



A D, holding at the end D a reel, upon which silk is wound and to which at C the cap B is to be screwed. The hinge at C facilitates filling of the cap B with carbolized oil or any other disinfectant, whilst the part D of A D is in the cap. At C there is a washer which prevents leakage. The spool D is readily removable from its encasement for winding silk upon it whenever the supply has been exhausted. Through C there is a perforation by which the silk passes out of A D and directly to the eye of the needle which is near its point (in this respect the figure is incorrect—it appears as though the needle were hollow, which is not the case). A straight and curved needle go with the instrument, either of which can be attached straight forward or at right angles with the same. It can be readily seen how, after once threading,

this troublesome manipulation need not be repeated, regardless of the number of sutures to be made, as long as the supply of silk holds out, which, when the spool is fully charged, is sufficient for several large operations.

MICROBOMANIA.—The symptoms and effects of this malady are wittily described by M. Paul Somans in the feuilleton of a recent issue of the *Gazette Médicale de Paris*. He speaks of it in connection with the numerous maladies which have recently been described, such as agarophobia, claustrophobia, and morphiamania. Microbomania is an affection of adult or middle age, sometimes attacking those in advanced years. It is most frequently observed among educated physicians, those most given to biological research, and almost always ambitious. It is characterized at the *debut* by a great desire for notoriety, accompanied by a slight degree of fever and a craving to find certain mobile corpuscles. The desire is soon followed by acts calculated to satisfy the special craving. In the end hallucinations are developed as to the

presence of corpuscles in impaludism, measles, scarlatina, even in mumps, and the minute organisms are charged with all the crimes imputable to each pathological individuality. The disease is imitative, and if several individuals under the influence of this form of mania should concentrate their attention on one and the same disease, they are very apt to find widely differing microbes.—*Med. Press, Jan. 9.*

HYPERICUM OIL FOR THE PREVENTION AND CURE OF BED-SORES: Dr. Herbert L. Snow writes in the *British Medical Journal*: Since my note on this subject in the *Journal* of December 8th, I have been favored by Mr. Fenn Clark, honorary consulting-surgeon to the Leamington Provident Dispensary, with a communication, from which I subjoin the following extracts: "I see that you have alluded to the value of hypericum oil. May I be allowed to add my testimony as I have made and used it in my practice for the last twenty years, with manifest advantage in severe cases of bed-sore? It is an old favorite in this country; and our American friends think highly of it also. I observe that you recommend a few days as the time which hypericum oil will require to perfect it. May I mention that my friend, who first introduced it to Mr. Garrard, and to Leamington generally, always recommended a period of three months in a sunny window, as it could not in less time acquire the reddish-brown tint? It is prepared from the blossoms of the *Hypericum medium perforatum*, which flowers in July."

SPONTANEOUS DISLOCATION OF THE HIP JOINT OCCURRING IN THE COURSE OF ACUTE ARTICULAR RHEUMATISM.—Dr. Stimson also presented a woman, thirty-seven years of age, who had an attack of rheumatism in December, 1882. The history of the attack was obscure, but the patient said that many joints were involved, that she remained ill for a long time, and that the deformity occurred as early, at least, as the following April. She finally came to Bellevue Hospital last summer, where Dr. Stimson saw her first in the month of September, and recognized a dislocation of the right hip joint backward upon the ilium. The interest of the case was partly in the rarity of the occurrence, and also in the facility with which the lesion might be overlooked. The subject had been recently written upon by French surgeons, and he had nothing to add except to say that the symptom of sudden cessation of pain, sometimes noted at the moment the dislocation occurred, did not appear to have been present in this case.—*N. Y. Med. Journal.*

CHARCOT'S CREED.—If I believe firmly that there exists in medicine a domain which pertains entirely to the physician, which he alone can culti-

vate and fructify, and which must necessarily be closed to the physiologist who systematically confined to his laboratory, disdains the instruction of the hospital wards, I no less firmly believe that the free intervention of the anatomical and physiological science in the affairs of medicine is an essential condition to its progress. I believe that practical medicine is not a real autonomy; that to live it must borrow; that without a constant scientific renovation it would soon become a dull routine. I think finally, that as regards the qualities of quick-sightedness, ingenuity, and practical skill, which all have to be perfected by use, and are not bestowed in completeness by nature, these are as much needed by the pathologist as by the clinician. This, very briefly, is my *credo*. I have always held to it, and I must always continue to do so.—*Medical Record*.

THE MICROCOCCUS OF PNEUMONIA.—In the sputa from fourteen cases of pneumonia (*Prof. Salvioli and Dr Zastlein*.) were found constantly ovoid cocci analogous to those described by Friedländer; they were frequently joined; seldom isolated; mostly in threes, fours, or in masses. The best staining material for them is a mixture of Bismark-brown and methyl-violet. They were first discovered about the third day of the disease though sparse, then becoming quite numerous about the sixth or seventh day, or when resolution begins and the râles return; later their number lessens and about the ninth or tenth day they disappear. The number of the micrococci, is independent of the severity of the disease or the height of the fever. The same organisms were found in the serum of fly blisters and in the patient's blood. By keeping the blood or serum in a warm place great increase in the number of the cocci was attained. Sputa from patients suffering from other affections of the respiratory apparatus, as well as blood and serum from persons free from pneumonia never contained these germs.

The pneumonic cocci were cultivated artificially by the authors. They obtained the best results with meat broth at about 100° F. as a culture fluid, having previously sterilized it by boiling. The cultivated cocci from the second to the fifth generation were injected under the skin of white mice and rabbits with the result of producing typical pneumonia; injection into the pleural cavity caused pleuritis with fibrinous exudation in which numbers of the organisms could be found.

Injection of the culture fluid without the cocci failed to produce pneumonia. It seems from these experiments that there exists in the sputum, blood and serum of pneumonia patients a constant germ, which can be cultivated through several generations and still have the power of producing typical pneumonia in animals when injected under the skin.—*Centralblatt f. d. Med. Wissenschaft*, No. 41, 1883.—*New England Med. Monthly*.

ST. JOHN LONG'S LINIMENT.—This old time liniment is still in use at the Pennsylvania Hospital, in this city, for stiff and rheumatic joints, and in general for cases in which a local stimulant and rubefacient effect is desired. Mr. Jacob Hecker, Ph. G., the apothecary of the institution, uses the following formula:

R Vitelli ovi, no.....viii
 Olei terebinthinæ,f ʒ xxiv;
 Acidi acetici.....f ʒ xvj;
 Aquæ.....f ʒ xxiv.

M.

The directions for its preparation are as follows: To the yolks, in a gallon bottle, add a small quantity of the water, and shake briskly together; then add the turpentine in successive portions, shaking the mixture briskly after each addition; then add the acetic acid, and lastly the water, in the same manner. For private practice the liniment is greatly improved by the addition of one drachm of good oil of lemon to each pint.—*Med. Times*.

IRON IN THE TREATMENT OF SKIN DISEASES.—Casarini has employed the perchloride of iron with advantage in a large number of chronic skin affections. He uses an ointment of from one to three grams of perchloride of iron to thirty grams of lard. He concludes from a number of observations that: 1. Perchloride of iron (internally administered) is the most efficacious agent in the treatment of simple or hemorrhagic purpura; 2. it is very useful to combat the anæmia which often accompanies certain cutaneous affections, such as rupia, ecthyma, and impetigo; 3. its external employment gives excellent and speedy results in ulcers of scrofulous and syphilitic origin; 4. in the form of ointment it constitutes a good remedy in the squamous skin diseases, especially in psoriasis. *Journal de Médecine de Paris*. November 24, 1883. *Med. Record*.

KAIRIN.—The *Lancet*, April 14, 1883, says that Filehne, in a recent number of the *Berliner Klinische Wochenschrift*, calls attention to the value of derivatives of chinoline which he with Fischer and König, has found of great value as an antipyretic. These are kairin, kairolin, and finally chinolinæ hydrate of Wischnegradsky. Of these kairin seems most likely to be of permanent value as an antipyretic. The muriate of kairin is a crystalline, clear, grayish-yellow powder, soluble in water, having a bitter, saltish, aromatic taste, which is disagreeable to some patients, and is therefore given in wafers, with a subsequent drink of water. Filehne gives five to seven grains every hour or hour and half. The remedy has shown a marked control over the temperature of croupous pneumonia. The urine, when kairin is being given, becomes dark green.

DR. H. C. WOOD'S SYPHILITIC TEST.—Persons are often unaware that they are suffering from syphilis. They honestly believe that they never had primary or secondary symptoms; these symptoms may, however, have been present, but so slightly marked as not to attract attention. Again, this is one of the points about which human nature often fails. People, even when death is staring them in the face, and their lives hang upon the truth, will make false statements. As we have a touchstone by means of which we are able to decide whether or not a patient is suffering from cerebral syphilis, I ask no questions, but apply the test where I have reason to suspect any disorder. It is a serious matter to mercurialize a patient, but it does no harm to produce iodism, so that when making the test I always employ iodide of potassium. If I find that ten grains three times a day produces symptoms of iodism I am almost sure that the case is not one of specific disease. If, on the other hand, the patient takes from one-half to one drachm of iodide of potassium and waxes fat thereon, I am almost sure that he is the subject of specific disease. There are some persons, not syphilitic, who will stand large doses of iodide of potassium, but such cases are rare, so that when a patient will take half a drachm of the remedy three or four times a day it may be concluded that he is syphilitic. I say this with one reservation. Persons who have gradually accustomed themselves to the use of iodide of potassium, as for instance, those who are asthmatic, will stand large doses of this drug, even when not suffering from syphilis. In such a case there will be the history of the long-continued use of the remedy. You must remember, also, that there is a syphilitic asthma, so that the relations of iodide to potassium to asthma are in many cases easily explainable. I shall speak of the method of using iodide of potassium when I come to consider the treatment.—*Gaillard's Med. Journal.*

THE DIET IN BRIGHT'S DISEASE.—In the *Chicago Med. Four. and Ex.* Dec., 1883; Dr Purdy suggests as the diet for the albuminuric patient the following: In the main it should consist of farinaceous articles, fish, vegetables, and fruits. Meats must be indulged in sparingly; very small quantities of lean meat alone being permissible. Soups should be prohibited; even the conventional beef-tea and beef extracts. Eggs should be excluded from the diet in albuminuria. It has been shown by Lehmann and Stockvis that when the white of an egg is introduced into the circulation, not only does that escape by the kidneys, but a surplus of other albuminoids accompanies it. Senator says the lesson will apply to meat as well as eggs. "Any excess acts in two ways injuriously—by increasing unnecessarily the amount of urea and other waste products in the blood; and also by pouring into the system an overplus of peptones

or other albuminous matters, which may simply have to be excreted, and cause irritation in the act." Cheese acts in a similar manner, and should not be used. Vegetables may be used freely, and the only ones to be avoided are the leguminous ones, which are too rich in albumen. Fats may be used as freely as the condition of the stomach will permit. Milk is one of the best articles of diet, but should not be too exclusive, as it does not furnish the elements of diet in a suitable proportion. The stomach should not be overloaded, it being an occasional observation that even in healthy persons albumen appears in the urine after a large meal. Small meals, more frequently repeated than usual, is a good rule to follow in such cases. Great discrimination is necessary in the matter of drinks in Bright's disease. Alcohol in large quantities, especially in concentrated form, is generally believed to be injurious. If alcohol be permitted at all, it must be well diluted, and it is preferable to give it with some alkali or neutral water, as Vichy or Apollinaris water in excess. Alcohol stimulates the interstitial changes in the kidneys if used in quantities, hence the allowance should be very small—not enough to disturb to any extent the general circulation. Claret, sherry, and Marsala are the least objectionable. As to malt liquors, they should, as a rule, be excluded, though it is stated that lighter pale ales or Bavarian beer are nearly free from objectionable qualities.

INJECTIONS INTO THE UTERINE TISSUE.—Dr. Schücking proposes to treat certain maladies of the uterus by injecting the medicament directly into the substance of the organ. We believe that this expedient, which he brings forward as new (*Berliner klin. Wochen.*), has been often employed in this country. The advantages of this method are two: it is local; it causes much less pain than subcutaneous injections. The remedies so employed are ergotin, Fowler's or Pearson's solution of arsenic, tincture of iodine, carbolic acid, and some other agents. The principal diseases thus treated are subinvolution, chronic metritis, fibroids, and some forms of displacement. For the performance of this operation the ordinary hypodermic syringe suffices, but the needle must have the necessary length to reach through the speculum into the uterus. Only concentrated solutions are suitable, since the tissue of the organ is too compact to admit more than a few minims.

That this method is not a mere fancy is proved by its employment in this city at the present time. We happen to know that a competent and enterprising female physician is using in this way a solution of carbolic acid, five per cent. in strength, for the relief of uterine cancer. The solution is freely injected into the tissue immediately subjacent to the cancerous mass. Too short a time has transpired to permit any opinion as to the ultimate result of this method.

TRACTION SUTURE.—Dr. Allis, (*Annals of Anat. and Surg.*), says that when a large portion of integument has been cut away, as in removal of the female breast, the healthy borders sometimes can not be fully approximated; and even an attempt to do so is accompanied with such a degree of tension that the sutures soon cut their way out. To distribute this tension, after drying the skin thoroughly, he applies strips of adhesive plaster from the margin of the wound in the direction he wishes the sutures to hold. He then passes his needle deeply through plaster and skin. After the sutures are in position, and before tightening them, he requests an assistant to approximate the margins of the wound by pressure from his hands, while he secures them by twisting the wire.

Sutures employed in this manner have a firm hold upon the plaster, exert their traction upon a large surface, are less irritating and harmful, and will continue an efficient action much longer than the ordinary integument sutures.

YELLOW OXIDE OF MERCURY OINTMENT IN CORNEAL ULCERATION.—Jonathan Hutchinson says "I do not doubt that there are at the present moment, whilst I am speaking to you, in the homes, the schools, the workhouses and the hospitals of England, some thousands of children who are suffering from ulcerations of the cornea, attended with intolerance of light, causing the patient great distress through many months and destined often to leave disfiguring and incapacitating scars. If my own experience may be trusted, I believe that three-fourths of these would be almost well in the course of a fortnight under the use of a very weak yellow oxide of mercury ointment. Since I knew the virtues of this ointment, I have been able to abandon almost entirely the use of blisters, setons and like painful measures and to effect the cure in the tenth of the time"—*Brit. Med. Journal*, Oct. 20, '83.

DECALCIFIED BONE DRAINAGE TUBES.—Prof. Gross gives the following directions for making decalcified bone drainage-tubes. Procure the femora and tibiae of a chicken or turkey, take off the periosteum, and place the bones in 16½ per cent. solution of official hydrochloric acid until they become soft; then cut off the ends and force out the endosteum; replace in the hydrochloric acid solution until they become very soft; fill them with horse-hairs, which must be removed if pus forms, as they will not allow it to pass. However, he recommends removing the bone tube in twenty-four hours, as it can only be absorbed by granulations, which render union by first intention out of the question.—*College and Clinical Record*.

Prof. Bartholow (*Col. and Clin. Record*) strongly

recommends salicylic acid, either by injection or internally, in large doses, for cystitis. Administered by the mouth, it acts after being excreted in the urine. He also says that potassium tartrate has been found effective—more effective, probably than any other remedy—in causing the solution of uric acid calculi. The treatment is to be long continued, in small doses, dissolved in much water.

ANTISEPTIC INHALATIONS IN PHTHISIS.—This method of treatment is not particularly new, but its use has been deprecated by many, on the grounds which are noted by Dr. I. Burney Yeo, in the *Brit. Med. Jour.*, January 12, 1884, as follows:

"Two objections have been made to the use of antiseptic inhalations, which are in singular opposition one to the other.

"The first is, that the vapors given off from the fluid which we drop on the sponge of the respirator are so strong and irritating, that they excite inflammation of the pulmonary tissues, and thus do injury; indeed, I have seen the antiseptic treatment of phthisis referred to in a medical journal as 'homicidal.'

"The other objection does not accuse of homicide, but is content with pointing out that we are very foolish people to imagine that any useful or appreciable amount of our antiseptic substances reaches the lung at all! I do not know which of these objections is least in accordance with experience.

"With regard to the first objection, I can state most positively that I have never seen any symptoms of irritation set up by antiseptic inhalations when properly applied. In sensitive persons, it is desirable to begin by at first dropping a few drops of the inhalant on the sponge, and slowly increasing the quantity; by that means, you will avoid all risk of irritation.

"The second objection scarcely needs answering at all; to some extent, it is a resurrection of the old dispute as to the use of topical remedies (in the form of vapors and sprays) to the respiratory surface, which was agitated fiercely many years ago, and the affirmative view thoroughly established by most elaborate and careful experiments by a number of observers in every country in Europe. The dispute and its results are fully related by Oertel in the work already referred to, and also by Dr. Solis Cohen, of Philadelphia, in his work 'On Inhalations.'

He has had good results, and after reading his paper, we would feel inclined to give a trial to the inhalation of a weak solution of corrosive sublimate, say 1 to 2000 or 2500, by means of a steam atomizing apparatus.—*Med. and Surg. Reporter*.

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ERGOT IN OBSTETRIC PRACTICE.

The place which ergot holds in obstetric practice at the present time is in marked contrast with the teaching and practice of a few years back. It is not long since ergot was given to the parturient woman in the most hap-hazard manner. Indeed there is room for the belief that some fossils in the profession continue to use it in that way still. Of course it has long been known that ergot contained elements of danger both to mother and child. Still it is but recently that the full gravity of these dangers has dawned upon the profession. More especially within the last year, this question has been studied and debated with the liveliest interest, with the result of modifying former opinions and practices in several essential points.

When ergot is administered at an earlier period than towards the close of the second stage, it is sought to hasten delivery by whipping up a lazy, or tired-out uterus, to the exercise of greater contractile force. The most serious danger to be apprehended from such a practice, is rupture of the uterus. The possibility of this untoward circumstance has long been known, but its occurrence was thought so rare that many obstetricians were willing to incur the risk. That this accident is not so very rare as generally supposed, may be inferred from the fact, that at a meeting of the St. Louis Medical Society recently held, one gentleman testified that he had seen six such cases, and another that he had seen two, within a year, all attributed to ergot. Another and more frequent

danger is the loss of the child. Not even every veteran obstetrician has witnessed a case of rupture of the uterus, but almost every practitioner has seen more than one child born dead, with darkened skin and swollen features, proclaiming louder than words the cause of death. Standing in the glare of the light of the present day, and looking back into the past, every practitioner of experience must be struck with dismay at the number of serious casualties observed in the path over which he has trodden. Untoward occurrences, then either held to be unaccountable or attributable to other causes, are now unveiled and shown to have been often the evil work of ergot. Of course the uterus may rupture, and the child may be still-born from other causes, but there is good ground for believing that most of these accidents, especially the former, result from the abuse of this drug. Violent and continued contraction, when it fails from any cause to expel the child, creates a liability to rupture, and prolonged pressure destroys the child by constricting the circulation.

Another and dangerous mishap sometimes following the administration of ergot, is irregular contraction; that is, the contractile force is not equal in all parts. When this happens, as it often does, however severe the maternal suffering may be, labor is just as likely to be retarded as advanced. This retardation may arise from one of two causes, or both at the same time. First, the contractile force exerted in certain zones may be rendered abortive by the inertia in other zones of the uterus; and secondly, labor may be retarded, and even made impossible, by a change in the direction of the expulsive force.

Then there is the danger of a lacerated cervix and a ruptured perineum. The former accident has received a good deal of attention of late from gynecologists, owing to the serious dangers and suffering to which it gives rise. Many troubles of the cervix not formerly understood are now known to originate in laceration. Laceration, of course, may occur without the use of ergot, but common sense teaches us that it is more likely to occur in rapid and violent dilatation, such as may follow the administration of ergot. The same remarks are applicable to rupture of the perineum, an accident often fraught with life-long suffering to its victim. It is not here pretended that these are novel facts. On the contrary they have been long known, but

somehow, it is but recently that their full significance has come to be realized.

The question now arises, has ergot any longer a place in midwifery practice? It certainly has, but its application is comparatively limited, and most carefully guarded. A few, indeed, have gone so far as to abolish it altogether, in all stages of labor, and use it only as a post-partum remedy. A large number hold that it ought not to be administered before the second stage of labor is passed, but that it may then be profitably given to facilitate the expulsion of the placenta, and to secure firm contraction. But the opinion more generally held, and the one practised by many of those allowed to speak with the weight of authority is, that after the head is born, it is not only safe but good practice to administer a full dose of ergot. Indeed it is now frequently the practice to administer ergot at this stage, or as soon after as possible. The object of course is to secure firm contraction so as to expel the placenta and prevent possible hemorrhage. Firm post-partum contraction is highly desirable in all cases. It empties the uterus of clots and remnants of membranes which otherwise might remain and cause much serious trouble. It is now known that severe and continued after-pains are owing to imperfect contraction, and that the more firmly the uterus is contracted the less severe these are likely to be. For this reason also it is good practice to administer ergot towards the close of labor in all cases, experience having abundantly proven that the after-suffering is thereby greatly diminished. After a time, should the after-pains be severe, a good plan is to combine opium with the ergot. Indeed so valuable is ergot at the close of labor that in many cases to neglect to administer it is only less criminal than to do so at an earlier stage. In all cases where there is reason for believing the uterus has not properly contracted, ergot should be steadily given for some time, combined with citrate of potassium, adding bromide of sodium when nervous symptoms are present.

But the most important office ascribed to ergot is in relation to post-partum hemorrhage. We have already referred to its use, in anticipation of the occurrence of that untoward and much dreaded accident, and doubtless its power to prevent this occurrence is much greater than its power to control it when it has actually taken place. We think every experienced practitioner will bear us out in

the statement that ergot is very uncertain in its action during the occurrence of hemorrhage.

Therefore the greater necessity for availing ourselves of the known power of this agent to prevent this accident. We may readily surmise causes for the comparative powerlessness of ergot to induce contraction after hemorrhage has taken place. The mental condition of the patient, the sudden prostration, and general loss of muscular tone, all render it improbable that the stomach is in a fit condition for speedy absorption, if at all. Under these circumstances the ergot should be administered hypodermically, for the well known reason that agents act more speedily and surely when introduced in that way. For this purpose care should be taken to keep on hand a clean and pure article. The so-called liquid ergot recently introduced, is a good and convenient form. Under all circumstances where it is important that action should be both speedy and certain, the hypodermic method should invariably be practised.

But the question will be asked, what are we to do when the os is fully dilated, the membranes perhaps ruptured, and the pains either feeble or entirely absent. In such cases we may safely exercise the virtue of patience, in the absence of all alarming symptoms. It may be that a little rest is all that is needed, and for that purpose a dose of opium may be given, although, instead of giving rest, it may, perchance, set up active contraction, ending in speedy delivery. Large and repeated doses of quinine, are both safe and effective in promoting uterine action, and should be resorted to when it is thought necessary to secure greater contractile force. Gentle external manipulation is also valuable in promoting contraction. But should all these means fail, and active interference called for, the safest resort is the forceps, followed by ergot, administered hypodermically to insure speedy and firm contraction.

MEDICAL SUICIDES.

A short time ago a charge was brought by the public prosecutor before the Central Criminal Court, London, England, against a woman named Hardie, for having procured her own miscarriage by illegal means and with the aid of her medical attendant, Mr. Haffenden. Feeling keenly the weight of the unjust accusation made against him,

Mr. Haffenden sought delivery from his trouble by committing suicide. The case came before the court in due course, and after a trial lasting the whole day, a verdict of acquittal was declared amidst loud applause. The chief witness for the prosecution broke down in cross-examination, and that, combined with the entire openness of Mr. Haffenden's proceedings and the evidence of Dr. Robert Barnes, the only medical witness called for the defence, left no doubt in the minds of the jury that the charge could not be upheld. The *Medical Times and Gazette*, in commenting on this painful case, says: It is to be deplored that the prosecution was ever instituted, and it is still a greater matter for regret that Mr. Haffenden did not abide in life to see his reputation vindicated. The case, though reported so meagrely in the journals as to be useless for medico-legal purposes, will serve as a timely reminder—first, to the Public Prosecutor and his advisers never to bring such another charge against a medical practitioner without an overwhelming mass of proof; secondly, to pregnant women that it is something more than a peccadillo to destroy the fruit within their womb; and thirdly, to medical practitioners to be more wary in the use of the uterine sound. Ladies have been known to go to gynecologists so well coached up in the symptoms of displacement that the sound has been introduced as a matter of course, and the doctor has not found out till afterwards that he has been made the subject of a plot."

We refer to this case for two reasons; first, because medical men, especially those who have to deal with diseases of women, are liable at any time to have charges trumped up against them, and therefore require to be constantly on their guard to surround themselves with every means of answering any false accusations that may be made against them; and secondly, to counsel medical men under all circumstances, if conscious of their innocence, no matter how dark the horizon may seem, or how damaging the slander may appear to be to their reputation, to fight it out. Let there be no compromise, and above all let there be no flying in the face of Providence by committing suicide in order to be delivered from impending trouble.

Many of our readers will remember the case of Dr. Edwardes, of Hounslow, who committed suicide about a year ago. In this case a charge of indecent assault was made by a Mrs. Bignell against

Dr. Edwardes, at the instigation of Dr. Whitmarsh, his partner, in order to drive the former into a disadvantageous and dishonorable dissolution of partnership. Instead of boldly meeting the charge and hounding down the villainous plotters, poor Edwardes, his quietus made, with a dose of prussic acid.

ANOTHER LIBEL CASE.—An action has been recently instituted by Dr. Lachapelle, editor of *L'Union Medicale*, against Dr. F. W. Campbell, *et al.*, of Montreal, to recover alleged damages incurred in consequence of a criminal action brought against the former gentleman. Some time ago an editorial appeared in *L'Union Medicale* to the effect that some French-Canadian medical students had received a private examination from the faculty of one of the medical schools of Montreal, and had received certificates which would enable them to practise in the United States. The drift of the editorial pointed to the faculty of Bishop's College as the guilty parties, and a criminal action for libel was brought against the proprietors of the journal in question. The bill, however, was thrown out by the grand jury, and the present suit has been entered by way of retaliation. The whole circumstance is much to be regretted, as it appears that both parties have been the victims of a fraud. The certificates referred to are believed to be forgeries.

HEALTH OF PANAMA.—Latest advices from this beautiful tropical city inform us that yellow fever prevails at present. In an article in the daily *Star*, written no doubt by Dr. Nelson, port surgeon, it is stated that while the disease is not epidemic, the fact of isolated cases occurring from month to month and from year to year, would point forcibly to the conclusion that the abominable neglect of all sanitary measures has allowed this disease to establish a permanent footing in their midst. The writer complains of the want of attention to sanitary matters, and says that with proper care Panama could be made one of the healthiest places in the tropics. It is hard to arouse the municipal mind to a sense of its duty. This is the experience of sanitarians in all parts of the world.

TRINITY MEDICAL COLLEGE TORONTO.—An official communication has been received by the authorities of this school from the Royal College

of Surgeons, England, enclosing the following resolution adopted by the Council of that body, formally recognizing the Fellowship Diplomas of the school. "That, as recommended by the Court of Examiners, Fellows by Examination of Trinity Medical School, Toronto, be admissible to the professional examination, for the Diploma of Member of the College on the same conditions as Graduates in Surgery and Medicine of recognized universities, as provided in paragraphs vii. and viii., section III of the regulations, and that, in consideration of the satisfactory examination, in medicine and midwifery, which such Fellows are required to pass, they be exempt from the necessity of passing in those subjects at this college." Such a recognition from such a quarter cannot but be very gratifying to the many graduates and friends of this school.

PATENT MEDICINE FORMULAS.—The following bill has been recently introduced into the House of Representatives of the United States: That from and after six months after the passage and approval of this act, no advertisement of any kind or nature or advertising device of any medical preparation, compound or prescription, or any punch, bitters, cordial or similar compound, or preparation to be used as medicine or mixed with food, liquor, wine or any other substance as a beverage or as food or medicine, shall be placed in or carried by the mails of the United States until the exact formula for the preparation thereof, together with a sample of the same, be placed in the Patent Office of the United States, with a sworn affidavit of the correctness of such formula and the genuineness of such sample, and the examination thereof by the proper officers designated therefor in said Patent Office.

APPOINTMENTS.—Dr. Marsden has been appointed a commissioner of the Marine Hospital, Quebec, *vice* Dr. James A. Sewell, deceased. The following gentlemen have been appointed "License Commissioners" (Act of 1876) for the districts named: J. S. Sprague, M.D., and J. S. Loomis, M.D., Hastings; J. Gunn, M.D., Middlesex; W. H. Blackstock, M.D., Simcoe; R. H. Abbott, M.D., N. Essex; A. McLean, M.D., W. Lambton; C. M. Gould, M.D., Northumberland; A. Robillard, M.D., Ottawa; A. Rockwell, M.D., of W. Hast-

ings. Thomas Moore, M.D., of Demorestville, has been appointed surgeon to the Canada Pacific Railway. Dr. Holmes, of Brussels, has been appointed treasurer of the Co. of Huron.

COSMOLINE UNCTION IN SCARLET FEVER.—There is scarcely anything so efficient in relieving the burning and itching sensation of the eruption of scarlet fever, as ununction of the body with cosmoline. It is applied by the hand once or twice a day as long as the itching lasts. These unjunctions soothe and calm the patient, relieve the itching and favor desquamation. When the itching and burning sensations are allayed, the body should then be sponged with a solution of hypo-sulphite of soda, of the strength of half a drachm to the ounce. This removes all the desquamated skin, promotes healthy action, and acts as a disinfectant, thereby lessening the tendency to the spread of the disease.

NEW YORK STATE MEDICAL SOCIETY.—The seventy-eighth annual meeting of this society was held in Albany, commencing on the 5th ult., under the presidency of Dr. Alex. Hutchins, of Brooklyn. Many valuable papers were read and discussed. The bill for the establishment of a State Medical Examining Board was also under consideration. The vexed question of medical Ethics, the old code *versus* the "new," occasioned a prolonged and heated discussion. The advocates of the new code were again victorious, their majority being fifteen, in a total of 232. Dr. N. A. Powell, of Edgar, Ont., was present as a delegate from the Ontario Medical Association.

ANATOMY ACT AMENDMENTS.—Steps are now being taken to secure certain much-needed amendments to the Anatomy Act, the object being to endeavor to secure a larger amount of anatomical material for the use of students and others interested in the prosecution of this interesting and important branch of medical study. The present Act is very defective in many particulars, and requires to be thoroughly revised and amended. It is the intention to frame the amendment upon the basis of the Quebec Anatomy Act, which, we are informed, is giving excellent satisfaction in the sister Province.

THE BERLIN POLYCLINIC.—The Berlin Polycli-

nic has recently celebrated its first anniversary. During this time upwards of two hundred medical men have attended the clinic. The subjects taught are, diseases of the eye, ear, nose, throat, larynx, skin, nerves, etc., Each course consists of one month, and is of a most practical character. Laboratories for chemistry, histology and bacterioscopy have been fitted up and every facility afforded for special study in these branches.

SUBSTITUTE FOR TRANSFUSION OF BLOOD.—Dr. W. J. Bull, of the New York Hospital, referring to the use of saline injections as a substitute for transfusion of blood in acute anæmia and collapse, says, that of nineteen patients subjected to the operation, when at the point of death, thirteen entirely recovered. He uses the solution employed by Synmann and also recommended by Schwarz, consisting of water ℥xxxij, chloride of sodium ℥jss, carbonate of soda grs xv.

THIRD BLOOD CORPUSCLE.—Several observers have made reference from time to time to a third corpuscular element of the blood. Recently Dr. Osler, of Montreal (*Med. News*), has been making investigations which lead him to believe that there exists a third corpuscle about $\frac{1}{6}$ the size of the red globules. It can be seen in the vessels of the living animal, and in the vessels of freshly removed bits of tissue. When the blood is removed from the vessels they run together and form granule masses.

CANCER OF THE BREAST.—The following, which is said to be Dr. Hunter McGuire's formula, has been much extolled in the treatment of cancer of the breast, which has passed the period for successful operation.

R Sodæ et calcis Hypophos..... ℥ ss
 Acid, phosph. dil..... ℥ ss
 Aquæ ad..... ℥ viii

Sig.—A teaspoonful in water three times a day.

ERGOT AND MORPHINE IN ECLAMPSIA.—A hypodermic injection of half a drachm to a drachm of fluid extract of ergot and half a grain of morphine, has a most marked controlling effect upon puerperal eclampsia. The value of morphine in this way has been abundantly attested by numerous observers, and the combination with ergot is worthy of trial.

PILOCARPINE IN SCARLET FEVER.—In the *Glasgow Med. Journal*, Jan., '84, Dr. Shearer gives the report of a case of scarlet fever, followed by coma and convulsions, which he successfully treated with pilocarpine. He used it hypodermically in doses of $\frac{1}{3}$ of a grain, after having previously tried the usual remedies including the hot-pack, and has no doubt that the beneficial effect was due to the pilocarpine.

A VEHICLE FOR SALICYLATE OF SODIUM.—Dr. Solis-Cohen (*Med. and Surg. Reporter*) suggests the use of equal parts simple syrup and liquor ammoniæ citratis as a vehicle for salicylate of sodium, flavoring with oil of wintergreen. This also makes a good vehicle for the muriated tincture of iron, to a great extent hiding its chalybeate taste.

NEURALGIA PENCILS.—So-called neuralgia pencils are the latest novelty in Germany. They consist of a mixture of menthol, thymol, and eucalyptol, fused and fashioned into small conical pellets which are fixed in suitable handles. The part affected being touched with the pencil, a slight impression of burning is at first produced, followed by a pleasant, cool sensation, and immediate relief.

ONTARIO MEDICAL COUNCIL EXAMINATIONS.—The professional examinations of the Ontario Medical Council will take place early in April. The final examination begins on the first prox. in Toronto and Kingston, simultaneously; and the primary on the 11th in Kingston, and the 14th in Toronto. See announcement in another place.

BRITISH DIPLOMAS.—The following gentlemen have successfully passed the professional examination and were admitted Licentiates of the Royal College of Physicians, London, Eng. W. Graham, M.D., (Toronto); W. S. McConochie, M.D., and E. R. Woods, M.D., (Trinity); and J. B. Loring, M.D., (McGill).

The following gentlemen have recently passed the necessary examination and were admitted members of the Royal College of Surgeons, England: F. U. Anderson, M.D., and N. E. Mackay, M.D., Halifax, N. S., and A. S. Kendall, M.D., Sydney, N. S.

THE ONTARIO MEDICAL LIBEL CASE.—In the

case of *Lennox vs. McCammon*, referred to in our last issue, the judge's ruling was sustained by the higher court, and the verdict for the defendant fully confirmed. The issue in this case cannot but be gratifying to the members of the Ontario Medical Council and the profession generally.

CORONERS.—Dr. G. E. Coulthard, of Fredericton, has been appointed coroner for the County of York, N. B. Dr. W. J. Charlton, of Weston, has been appointed coroner for the County of York, Ont. Dr. J. D. Ross, of Moncton, has been appointed coroner for the County of Westmoreland, N. B.

OMISSION.—The name of Dr. Thom, councillor for Streetsville, was accidentally omitted in our last issue; also Dr. Bucke, of Palermo, and Dr. McLay, of Woodstock, Ont. Dr. Faulkner, of Stirling, has been elected warden of the county of Hastings.

As we go to press we learn with deep regret of the death of Dr. C. H. Lavell, eldest son of Dr. M. Lavell, of Kingston. We have also received an obituary notice of the death of Dr. J. R. Smith, of Harrowsmith, written by his former fellow-student, Dr. Dupuis, of Kingston. It will appear in our next issue.

A LONDON doctor was sent for by a lady in Chelsea. The lady apologized for asking the doctor to come such a distance, when the doctor unguardedly said: "Don't speak of it. I happened to have another patient in the neighborhood, and can thus *kill two birds with one stone.*"

DR. WILLIARD PARKER is eighty-three years old; Alonza Clark, eighty; A. C. Post, seventy-seven; Isaac E. Taylor and Austin Flint, seventy one, and Frank H. Hamilton, seventy. Some of these distinguished medical men are still in active practice, notwithstanding their great age.

SIR BENJAMIN BRODIE'S PRESCRIPTION FOR GOUT.—R. Pil. hydrargyri, ext. rhei, ext. coloc. co. aa ʒj; ext. colchici acet., gr. xv. Ft. pil. xv. Sumantur tres horæ somni pro re natâ.

Prof. Balfour, Dean of the Medical Faculty of the University of Edinburgh, died recently at the age of seventy-five.

Books and Pamphlets.

A SYSTEM OF ORAL SURGERY, being a treatise on the diseases and surgery of the Mouth, Jaws, Face, Teeth, etc., by James E. Garretson, M.D., Dean, Philadelphia Dental College, etc. Fourth edition, revised and illustrated, pp. 1002. Philadelphia: J. B. Lippincott & Co.; Toronto: Hart & Co.

The work is well written, full and complete, both in description and illustration. Although a large portion of the book is taken up with dentistry proper, ample justice is done to the various surgical diseases and malformations of the face, nose, mouth and palate, and the operations for removal of the tongue, upper and lower jaw, etc., etc. The author has spared neither labor nor expense to render the work a complete and comprehensive exponent of oral surgery. It is supplied with a copious index. We heartily commend it to the attention of the profession in Canada.

THE STUDENT'S HAND-BOOK OF CHEMISTRY, with tables and chemical calculations. By H. L. Greville, F.I.C., F.C.S., chemist, London, Eng. E. & S. Livingstone, publishers, Edinburgh.

The author has endeavored to simplify the subject of chemistry as much as possible. The work deals with both inorganic and organic chemistry, and much information has been compressed into small compass. It is well adapted as a hand-book for medical students, being furnished with a copious index, and the text given in such a form as will render it readily accessible to the student. We commend the work to the attention of Canadian students.

A HAND-BOOK OF SKIN DISEASES AND THEIR TREATMENT. By John R. Kippax, M.D., L.L.B., Professor of Principles and Practice of Medicine and Medical Jurisprudence in the Chicago Medical College, etc. Second edition, revised, enlarged, and illustrated. Chicago: Duncan Bros. 1884.

We noticed at some length the first edition of this work, and would here add that the present edition has been carefully revised, many parts rewritten, illustrations added, and the book considerably enlarged. The work is essentially a digest of practical dermatology. It gives in small compass the classification, etiology, symptomatology, diagnosis, and treatment (Homœopathic) of cutaneous diseases.

THE EDINBURGH MEDICAL SCHOOL GUIDE TO STUDENTS, 1883-84. E. & S. Livingstone, publishers, Edinburgh.

This little work contains all the information required for graduation in medicine and sanitary science, also for the Licenses of the Colleges of Physicians and Surgeons. It also contains the examination questions, set by the University and Colleges, for several years past.

The International Review of Medical and Surgical Technics (quarterly), edited by Dr. J. H. Warren and others of Boston, is a new adventure destined to fill a useful place in medical journalism. The price is \$2 per annum. It is devoted to the illustration and description of new instruments, appliances, and methods of operation.

INGROWING NAILS.—The following practical hints on the management of ingrowing nails are from the *Journal of Cutaneous Diseases*.

When the nail threatens to grow into the skin, or has already injured it, the first indication is to put on a sock of moderate size and to remain quiet. Afterwards the nail is to be scraped on the affected side till it is sufficiently thin; then it is to be seized with a delicate forceps, raising it in a sense inversely to its natural curvature. This having been done a small lamina of lead of a few millimeters' thickness is to be inserted beneath the nail, and after folding it over the toe, it is to be fastened there with a strip of plaster. In this manner the granulation being no longer in contact with the margin of the nail, the pain ceases, and the sore heals more or less rapidly; during the whole of this time the apparatus should be frequently inspected, so that the lamina of lead may not become displaced. Besides this it is necessary to scrape the nail every two or three days, so as to keep it thin and flexible, until the skin returns to its natural state, and can resist the pressure of the nail, and then the lead is removed. Hebra treats ingrowing nails in the following manner: Cut some flakes of lint of the length of the lateral groove of the nail, or a little longer. The lint is to be placed under the nail parallel to the groove; then with a flat probe introduce the lint, thread by thread, between the flesh and nail. Thus the parts are separated, with the little cushions of lint lying between. The sulcus is then to be filled with pledgets of lint, and finally long narrow strips of adhesive plaster are to be applied, always from above the inflamed sulcus downward, in such a manner that the latter is still farther removed from the margin of the nail. With such a dressing applied with sufficient care, there is no pain whatever; and

the patient can in a short time put on his ordinary stocking, and walk without trouble. After twenty-four hours the strips of adhesive plaster are to be removed, being previously softened in a bath of tepid water. This dressing is to be repeated daily; and in from two to four weeks it will be found that the toe is entirely well.—*Medical Age*.

SMALL DOSES.—The *Medical Times* and *Gazette* contains an article by Dr. J. C. Thorwood, in which he states the doses of medicines as set forth in books are often needlessly large when a gradual alterative or specific action from the remedy is desired. Calomel and other preparations of mercury, given in repeated small doses, in his experience, have proved valuable in the treatment of peritonitis, pleurisy pericarditis. He gives an example: A lady with knees drawn up in bed, rapid small pulse, black tongue and incessant vomiting. She had been confined about five days previous, and was taking repeated doses of opium. The opium was withdrawn and calomel administered in one-third grain doses every two hours. Under this treatment the vomiting ceased and convalescence set in.

The dose of tincture of aconite is from five to fifteen minims (British Pharmacopœia) but better results have been obtained from a dose of one or two minims every two hours in commencing inflammation.

The writer knows of no drug so generally useful in the treatment of asthma as arsenic, and in fifteen years' experience has seen a great many cases of spasmodic asthma that seemed to get quite well under the influence of small doses of arsenic. He never exceeded the dose of three minims of either Fowler's solution or of liquor sodæ arseniatis three times in the day.

In his hands excellent results have been obtained from a persevering use of very small doses (one-fiftieth of a grain) of strychnia in promoting the restoration of exhausted nerve function, while larger doses do but add irritation and eventually increase the exhaustion. Tincture of nux vomica taken in doses of one to two minims, fasting every morning, is very useful in the cure of chronic constipation of the bowels while five or ten minim doses three times daily act very much like quinine in checking the action of the liver, and causing disturbance of the system.—*New Summary*.

ON SCHOOL HYGIENE.—This was the subject of an address before the American Health Association, at its last meeting, by Dr. Charles J. Lundy, of Detroit. He sums up tersely as follows what is required to remedy existing defects:

1. Avoid the cramming process in education, and the nervous excitement due to the spirit of rivalry.

2. Reduce the number of subjects in the curriculum, and shorten the periods of study.
3. Ventilate the school rooms in accordance with the most approved methods.
4. Regulate the temperature of the school-room—an atmosphere which is too warm debilitates the system.
5. Provide properly constructed and arranged seats and desks.
6. Instruct pupils to sit erect, and to hold the book or paper at least twelve inches from the eye.
7. Provide highly myopic pupils with proper spectacles, which will enable them to read at the natural distance of twelve inches.
8. Furnish pupils with well-printed books.
9. Furnish abundance of light, without producing glare. Let it come from the left side if the room is narrow, from both sides if the room is wide.
10. Provide for the physical education of school children, and teach them the importance of outdoor exercise.

PROF. BARTHOLOW says iodide of ethyl is a very valuable antispasmodic, singularly, and immediate beneficial in spasmodic asthma, also lessening liability to subsequent attacks. In capillary bronchitis it is conspicuously beneficial, as also in catarrhal pneumonia. In chronic bronchitis it is a most valuable agent, from its local action. It will probably take the place of iodine vapor for respiratory diseases. The dose is gtt. v-xx three or four times a day, by inhalation, generally from a handkerchief.—*Coll and Clin Record.*

FOR TORPIDITY OF THE LIVER.—Professor Delafield, of New York, recommends the following :

R Podophyllin,	grs. ij,
Hydrarg. bichlorid.,	gr. j,
Pulv. ipecac.,	grs. iv,
Ext. colocynth co.,	grs. x. M.

Ft. pil. No. xx.
Sig. One pill three times a day.

PAINLESS PARACENTESIS.—Since general etherization is sometimes interdicted owing to some heart trouble, etc., and since the ether-spray is disagreeable, owing to the odor of the ether, the following, not very new, but practical suggestion of Dr. F. P. Stapes in the *Brit. Med. Jour.*, Nov. 17, '83, is worthy of note. He applies a mixture of salt and ice for about twenty minutes before the operation. This completely destroys all sensibility in the part.—*Med. and Surg. Reporter.*

ETHER IN TYPHOID FEVER.—A French physician considers hypodermic injections of ether very

valuable in the adynamic forms of the disease. He reports five cases so treated. Two injections, of twenty drops each time, were made daily, and under its influence the patient was aroused and delirium ceased. In pneumonia, these injections are of the greatest utility, as they are in every malady assuming a typhoid form.—*Med. and Surg. Reporter.*

At the clinic (*Col. and Clin. Record*) Prof. Pen-coast's wrist tourniquet is used by him. It consists of two compresses over the ulnar and radial arteries, covered by a strip of adhesive plaster extending almost around the wrist. He reported an operation in which the palmar arch was cut, and hemorrhage was prevented by this tourniquet alone, no ligatures being used.

NEURALGIA—Prof. Roberts Bartholow recommends equal parts of chloroform, camphor and hydrate of chloral, as an efficient local application to allay the pain of neuralgia. This simple mixture, he recently stated to his class, is very rapid in its anodyne action on the part to which it is applied.—*Med. Summary.*

PROF. PARVIN says that a strict milk diet is the best and almost certain remedy for the albuminuria of pregnancy. A recent case thus treated was delivered of twins, no convulsions occurring.—*Coll and Clin Record.*

Prof. Rogers, last week, demonstrated the folly of decolorizing solutions of iodine, the reaction being really the formation of an iodide and iodate.

Births, Marriages and Deaths.

On the 23rd ult., the wife of Dr. J. Fulton, Toronto, of a daughter.

At Chatham, N. B., on the 13th ult., John Thomson, Esq., M.D., aged 75 years.

At Whitevale, Ont., on the 4th ult., J. R. Tabor, M.D., aged 43 years.

In Chicago, on the 26th of January, Alexander C. Savage, M.D., formerly of Ottawa.

At Harrowsmith, Ont., on the 17th ult., Dr. J. R. Smith, aged 45 years.

In Kingston, on the 26th ult., Dr. C. H. Lavell, eldest son of Dr. M. Lavell.

* * * The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.