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The Northern Lancet.

Gleanings from the journals of the World all that is new in Medicine, Surgery and Pharmacy, placing monthly before its readers in a condensed form Medical, Surgical, Obstetrical and Pharmaceutical advances in both hemispheres.

WINNIPEG, JANUARY, 1890.

HOSPITAL REPORTS.

CASES TREATED AT THE WINNIPEG GENERAL HOSPITAL DURING THE MONTH OF DECEMBER.

Under the care of Dr. A. H. FROSTON, Professor of Surgery in Manitoba Medical College.

Reported by Dr. J. G. Calder, House Surgeon to the Hospital.

COMPOUND COMMUNITED FRACTURE OF FRONTAL BONE WITH DEPRESSION—RECOVERY.

Willie T——, age 12, was kicked in the forehead by a horse about noon on Nov. 7th, admitted to hospital about an hour afterwards, in a semi-comatose condition. A large blood tumor found covering the whole forehead, there being two small wounds, one three inches above and a little to the outer side of the right eye, the other two inches above the outer angle of the left eye. Examination reveals crepitus over the whole forehead, and on pressing close to opening over left eye brain matter oozed out.

Operation.—Patient was given an anæsthetic and the two openings were connected by an incision down to the bone, and the clot turned out. This incision revealed a depressed fracture of the whole forehead. To facilitate matters the incision was carried upwards and outwards from the left extremity of the wound for a distance of about two inches, and downwards and outwards from the right extremity of the wound for about two and a half inches, thus making a *N* shaped incision with two triangular flaps, one of which was reflected up and the other down.

On laying bare the bone those portions beneath the small original wounds were found to be seat of stellate fractures, and

on pressing the bones gently brain substance oozed from both points.

Four complete fractures were found across the forehead, the upper of which was arched upwards, one crack extended around the head to the left, another around to the right for an unascertained distance, there was also one fracture extending down into each orbit, and one running down past the outer angle of the left orbit, the whole frontal bone being depressed and driven in under the vault of the cranium for a distance of about three fourths of an inch.

The small shattered fragments at the corners were picked out, three sharp projecting corners were sawn off to facilitate elevation and the bone was drawn downwards and outwards from beneath the vault of the cranium and elevated; holes were drilled through the pieces and three silver wire and two catgut sutures put in; one piece about two inches long and one inch broad was almost completely separated, the two catgut sutures being used to keep it in place.

The whole was closed by a continuous suture, two of Macewen's decalcified chicken bone drains, each about two and a half inches long were inserted and stiched into place, their ends opening at the points of the original wounds, but not projecting beyond the skin, an abundance of antiseptic gauze was put on, covering the whole top of the head, ears and eyes and kept in place by gauze and starch bandages.

On being put to bed, temperature was 99.2. Respiration, 37; pulse, 100; very delirious, moaning, crying out; some vomiting and twitching of the muscles. The pulse, respiration and rectal temperature were taken every hour. Seven hours after the operation the rectal temperature rose to 100.8, which was the highest reached.

First day.—Morning temperature normal, pulse 106, respiration 26. Evening temperature 100.4, still delirious and moaning, complains of weight and compression of head.

Third day.—Morning and evening temperature normal, not so delirious but still complains of pain in the head, pulse 86, respiration 18.

Seventh day.—Still a little delirious, temperature 99, respiration 20, pulse 60; beginning to sing a good deal, gets angry very readily.

Fourteenth day.—Still sings a good deal, is not so irritable, is now perfectly rational; respiration, pulse and temperature still normal.

Twenty-first day.—Dressing removed for the first time, everything found united and drainage tubes absorbed, no trace of pus. Two small ulcers the size of a five cent piece marked the points of entrance of the drainage tubes. Another small dressing was put on to protect the head from injury, the eyes and ears being left exposed.

Twenty-third day.—Sitting up in bed.

Thirty-third day.—Out of bed running around the ward.

Forty-fourth day.—Discharged perfectly cured, in possession of all his faculties, without anything of any kind to show that he had been injured except the almost imperceptible scar across the forehead. The great advantage of using decalcified bone drainage tubes was clearly shown in this case, for they not merely drain well, and become absorbed, but also allow the first dressing to be a permanent one, and so long as it is antiseptic all is well. In this instance it was unchanged for 21 days. In so grave a case, the whole forehead depressed, the bones shattered, and considerable loss of brain substance, the excellent result is very congratulatory indeed. As consciousness began to be restored the psychological symptoms manifested were of extreme interest.

REMOVAL OF THE UTERINE APPENDAGES—RECOVERY.

S— S—, age 29, unmarried, admitted Oct. 30th. Came from Brandon.

Nine years ago, when she was pregnant three months, patient strained herself lifting a boiler. She miscarried the next day. She had "inflammation" following this which kept her in bed for four months and a half and under a doctor's care for a year and a half more. Six months after the miscarriage she commenced to menstruate again, and it continued with fair regularity until March 1889, but was always very

painful. During the intervals she had a constant vaginal discharge often very offensive in character. In March last all her symptoms became greatly exaggerated, menstruation became very irregular and frequent, a profuse purulent discharge appeared between the periods. A swelling appeared on the left side in ovarian region, this varied very much in size, sometimes entirely disappearing, all her symptoms being very much increased when it was large. Examination reveals: Uterus low down; os soft eroded; movement of uterus in every direction caused great pain. An exceedingly painful swelling found in Douglas pouch, a glairy mucus found oozing from os. Hot vaginal douches were given twice daily and tampons of glycerine and belladonna applied after each. Hot fomentations externally for pain. This was continued for two weeks when local application of pure carbolic was made to the cervix and the douches continued. An application of pure carbolic was next made to inside of uterus by means of an applicator, douches continued. Unguentum, iodine and blisters applied externally over ovaries, wet and dry cupping tried for pain in back, and morphia given internally, but no relief was obtain. Patient was now given anæsthetic, uterus found pointing in normal direction, but three quarters of an inch deeper than normal, blood escaped on withdrawing probe. A lump about the size of an egg was found in Douglas' pouch, which was judged to be the left ovary, tubes found thickened and prominent. On passing sound in direction of left tube it was found patulous, the probe passing readily into it for a short distance, the right tube could not be entered. A considerable quantity of pus escaped from uterus on withdrawing probe.

Operation.—Patient was given a hot bath every day for several days, a carbolic bath the evening before the operation, the abdomen and pubes were shaved, washed with ether and alcohol, a moist bichloride dressing applied and a dose of castor oil was given the night before, and an enema the morning of the operation. Every antiseptic precaution in regard to room, bed, bedding, linen, instruments, sponges, operator and assistants, nurse and

attendants was taken. A short incision was made, sufficiently large to admit two fingers. The great thickness of the abdominal wall, fully two inches, the very deep pelvis, and the firmly bound down ovaries and tubes presented a formidable case to deal with. "Even in the hands of surgeons of the highest skill, it has not infrequently been abandoned as impracticable." (Page 195, Greig Smith) Rather than depend entirely on the fingers the operator preferred to enlarge the incision to five or six inches, and operate by the aid of sight.

Both ovaries were found enlarged filled with cysts prolapsed into the pouch of Douglas and firmly adherent to one another to the uterus in front of the rectum behind, and to a loop of intestine in the pouch, the tubes being enlarged and thickened. They were separated and removed, the pedicles secured with Lawson Tait's knot. Some difficulty was experienced in freeing them on account of the number and firmness of the adhesions. Oozing of blood was checked by sponge pressure. The peritoneum alone first closed by a continuous suture, afterwards the abdominal wound was closed by sutures extending down to but not through the peritoneum. A glass drainage tube was used extending down into Douglas' pouch, and a moist bichloride dressing put on, the end of the drainage tube extending up through the dressing. The tube was packed with moist gauze, and the whole covered with a large pad of moist bichloride gauze and a binder applied. Forty minutes being consumed by the operation proper.

Considerable vomiting, cramping pains and tympanites following operation. Thirst was relieved by enemata of water, the flatulence by citrate of magnesia till the bowels moved, the pain by morphia and atropia hypodermically. The pad covering the tube and the packing in the tube were removed at first every four hours, a soft catheter passed into the tube and the bloody serum pumped out with a glass syringe. The urine was drawn off every 5 or 6 hours, or rather when asked to be done. There was very little oozing, at no time were there more than a few drachms obtainable as most of it drained

up through the packing in the tube into the pad which it discolored.

First day—Evening temperature 100·2, pulse 112.

Second day.—Evening temperature 99·8, pulse 108, pain not so bad, but thirst tympanitis and retching still severe, serum pumped out and packing in the tube changed every eight hours.

Third day.—Oozing very slight, pad very slightly stained, only a few drops could be pumped out, evening temperature 100·4, pulse 96.

Fourth day.—Nothing could be pumped out, drainage tube removed, and dressing removed and re-applied, wound found everywhere united.

Following the dressing patient complained a great deal of cramping pains and tympanites, retching again became severe, and temperature rose to 102·8, pulse 130.

Fifth day.—Morning temperature 99½, pulse 104; evening temperature 100·8, pulse 100, resting better.

Sixth day.—Morning temperature 99·6, pulse 88, very much improved.

Following this patient went on well without any bad symptoms.

Thirteenth day.—Dressing changed, opening for drainage tube completely closed.

Twenty-seventh day.—Put back into general ward, still without any bad symptoms.

The points of interest in this case, are many:—1. As far as can be ascertained this is the first time this operation has been performed in Manitoba, and certainly a more difficult case could not well be presented. 2. The "Furies of Abdominal Surgery" though showing angry signs were always kept under control. 3. "When not a drachm of serum could be withdrawn from the pouch of Douglas" it was then deemed necessary to remove the drainage tube.

CEREBELLAR ABSCESS.

T. J. C.—, ago 24, farmer, admitted November 17th, with typhoid fever. When quite young patient lost use of right ear as result of an injury; this ear has troubled him ever since, always aching a great deal, but never discharging much.

During the first two weeks of the typhoid, headache was excruciating; temp. ranged from 100—104.2. The attack being a severe one so far as the ordinary symptoms were concerned.

36th day—eight days after—temp. normal; complained of earache; examination revealed a perforated membrane and a copious discharge of pus. For three weeks following, the ear was syringed out with hot 1-200 carbolic solution several times every day, for the last few days every hour; on each occasion a considerable quantity of pus was washed out. The pain at last became so severe that nothing but morphia would relieve it, the patient during the whole time being in a very low condition, the heart very weak; there was considerable drowsiness, answers were unwillingly given, delayed, but intelligent; some vomiting, occasional rigors; temperature at first, subnormal, afterwards slight elevation; pulse varied from 80 to 120 very weak, obstinate constipation afterwards, towards the close incontinence of excreta, cervical swelling along the jugular vein, some loss of coordination. The diagnosis of cerebellar abscess was made by Dr. A. H. Ferguson. It was decided first to open the mastoid cells to see if any relief would be obtained and if not to trephine the cerebellum in Macewen's line.

Ether was administered and the mastoid cells drilled, a free opening being made into the middle ear. No puss was found in the cells. The opening was loosely packed and patient put to bed. He recovered from the ether much better than expected.

For three days following felt very much relieved, when the symptoms became more aggravated and the question of trephining the cerebellum arose, but unfortunately the present epidemic of influenza made it impossible to call a consultation, as both operator and most of the members of the hospital staff were prostrated with the disease. Patient died on the seventh day following operation.

Post-mortem revealed an abscess about the size of a small egg in the right lobe of the cerebellum, it had come almost to

the surface, pointing downwards and backwards to a point an inch and a half behind and an inch below the external auditory meatus. No phlebitis of lateral sinus. Slight meningitis at base of brain. The puss from the abscess was very foul, other parts of brain normal.

If the cerebellum had been trephined at Macewen's landmark, as was intended, the exact spot in which the the abscess was pointing would have been struck.

HEALING OF WOUNDS WITHOUT DRAINAGE.

BY DR. LUDVIG HEKTOEN,

Pathologist to Cook County Hospital, Chicago.

As far as the records of the hospital during the past year go, primary union without any untoward results has been observed just as frequently, if not more so, in cases where drainage was suppressed as in presumably aseptic cases where it was established.

In all cases the field of operation was rendered thoroughly aseptic by scrubbing with soap and water, shaving, washing with ether or alcohol and then with sublimate solution. Whenever possible this would be done a day or two beforehand and a wet dressing applied to be removed immediately before commencing to operate. During the course of the operation rigorous antisepsis was always observed; pieces of bichloride gauze were used for sponging and bichloride solution for irrigating; careful hemostasis would be made before closing the wound, which was done as accurately and tightly as possible without strangulation, so as to avoid the formation of any dead spaces. Silk rendered aseptic by boiling in water and preserved in alcohol was used for ligatures and sutures. Finally a copious antiseptic dressing would be applied exerting quite firm and uniform pressure. Up to the present time but very few surgeons have had the courage to so implicitly trust in their control of the technique of asepticism as to forego drainage in wounds in operations of any magnitude.

Jules Boeckel (*American Journal of Medical Sciences*, July, 1889,) in a recent

communication to the Societe de Chirurgie stated that he employed no drainage whatever, and gave the results obtained in thirty-three major operations among which were extirpation of the breast, resection of the knee, amputation of the thigh, excision of cervical and inguinal glands, etc. He had no deaths attributable to the suppression of drainage. In the discussion that ensued Ollier stated that he had not yet dared to omit drainage in resections of the knee; in his opinion it would certainly be unsafe to dispense with it in cases where there were extra-articular purulent foci.

The results in the cases reported that an aseptic wound needs no drainage. It is well known that the large effusion around a fracture disappears without any symptoms, and in the successful healing of wounds according to Schede's method granulations rapidly replace the aseptic blood clot. If the fluids exuded after an operation or an injury remain free from infection they will be absorbed into the system without any disturbance in the wound itself or of the general health. Drainage then, is not really indicated in aseptic wounds and a wound, aseptic at the end of an operation, certainly runs a much smaller chance of infection subsequently when drainage is suppressed than when it is used. Mr. Chenieux, in an article in *Revue de Chirurgie*, for Nov., 1886, states that drainage is an enemy to primary union because the drain, no matter of what nature, occupies a certain amount of space where the margin of the wound cannot be brought together, and because the innocuous, aseptic exudations, capable of reabsorption but lost in case of drainage, may become the vehicle for microbes if through antiseptics should not be secured during the dressings. It is only in infected wounds or in wounds where the possibility of infection may be strong, that drainage is clearly indicated. It has long been customary to close smaller wounds without drainage; if accurate coaptation and asepsis can be secured in extensive wounds, and they can in most cases, the conditions for primary union are just as favorable in large as in small wounds.

In order to secure primary union without drainage, the ideal result, the following conditions may be considered essential: The wound must be left aseptic at the end of the operation by vigorous anti or asepsis during the course. All the minute details of antiseptics and asepsis must be fully mastered. Solutions of carbolic acid should not be used for irrigating as it corrodes the tissue, dissolves the occluding thrombi, and increases exudation. Perfect hæmostasis must be secured before the closure of the wound so as to reduce the pressure within the wound to a minimum. The wound must be accurately and firmly coapted and closed with tension, approximation and buried aseptic sutures, if necessary, in order to prevent the formation of any dead spaces in which fluids might accumulate. Finally, a suitable antiseptic dressing should be applied so as to exert equable pressure, and permitted to remain if no positive indication for its removal arise, until primary union has been secured.

Perhaps the dry operation of Landerer may be found especially suitable in cases where primary union without drainage is desired. (*Arch. f. Klin. Chir.* XXXIX-1. p. 216, 1889.)

Landerer avoided bringing any aseptic solutions in contact with the wound, which is dried with pieces of bichloride gauze and packed at once in those parts where the knife is not at work. Among many other advantages for this dry method of operating he claims rapid and certain healing, as the absolutely dry wound surfaces are peculiarly well suited for primary union.

Conclusions:

1. Primary union throughout the entire extent of the wound is one of the principle objects of antiseptic and aseptic surgery.
2. An aseptic wound needs no drainage.
3. The suppression of drainage simplifies wound treatment, reduces the chances of infection, and makes primary union of the whole wound possible if it be aseptic and correctly closed.—*North American Practitioner.*

TOOTH EXTRACTION AND ITS ALTERNATIVES FOR THE RELIEF OF PAIN.

BY H. C. QUINBY, L.D.S.I.,

President of the Midland Branch of the British Dental Association.

The following remarks are intended as an earnest remonstrance against the practice of extracting teeth for the mere relief from pain, a practice which those country surgeons who are, by reason of distance from special dental aid, compelled to pay attention to the teeth of their patients seem to think is the only possible form of treatment, and therefore perfectly justifiable. I am aware that many who call themselves dentists are guilty of a still more extravagant waste of human teeth; often, I fear, prompted by a motive of self-interest, which ought to be a sufficient reason for striking their names off the register; but, while an appeal to these men—if, indeed, any appeal would influence them—would be more in place in the pages of the dental journals, those special journals do not, as a rule, come into the hands of general practitioners of medicine and surgery, and no country surgeon can do without his *Lancet*. I constantly hear cases like this: "I got toothache while I was staying at such and such a place, and, as there was no dentist near, I went to the doctor, and he took the tooth out." There is never any mention of an effort to save the tooth, and in these days, when surgery is making such rapid advancement in every direction, it is time that such empiricism should come to an end. I doubt if there is any other organ possessing a title of the functional importance to the maintenance of human health and strength that rightfully belongs to a grinding tooth which would not receive far more consideration if it were a source of pain than any surgeon ever thinks of giving to a tooth.

When a tooth aches, the first suggestion is to have it out. But I do not hesitate to say, after many years of experience, that it is never necessary to extract a tooth merely for the relief of pain. That there may be, and are, many other reasons of sufficient importance to justify extrac-

tion I of course admit, and these should have proper consideration in cases of toothache; but what I mean to say is simply this, there are two forms of pain arising from teeth, which will include at least 90 per cent. of all the cases that will come to a dentist in good practice; we will call these primary and secondary toothache, and I contend that in neither of these is extraction ever the remedy to be chosen without careful deliberation.

Primary toothache is congestion of the tooth pulp; the unyielding walls of the pulp cavity permitting no expansion, there is intense pressure on the nerve tissue, and consequent pain, which finally terminates by strangulation of the pulp. This is true toothache, arising in the tooth, but it may be felt in the terminals of any of the branches of the fifth nerve on the corresponding side of the face, and is rarely felt in the tooth where it originates, unless there is suppuration in the pulp, in which case the peridental membrane will be affected. It will be obvious that many cases of so called neuralgia in the face are simply toothache, and a careful search will generally reveal the offender, but there will be no occasion for extraction. Careful excavation, sufficient to allow an escape of blood from the pulp, will at once relieve the pain, and an arsenical dressing will devitalize the pulp, and there need not be anything like the pain of extraction. To complete the operation, the pulp must be removed from the root canals, and these filled to the apex; but this will call for special skill, and no harm will be done if there should be three or four weeks of delay. Nothing in a dentist's experience is more melancholy than to look into a mouth and to see six or eight detached grinding teeth without an antagonising tooth in the opposite jaw.

The secondary form of toothache is usually admitted by the sufferer to be toothache, because the pain appears to be intensified by occlusion with an opposite tooth and by pressure of any kind. In reality the pain is caused by gangrene of the pulp, and I am quite aware that this is considered so serious a matter that most surgeons would order immediate extraction, but it is not at all a necessity. It is a matter of every day practice with

me and with thousands of other dentists to treat alveolar abscess successfully and make the teeth useful and comfortable. There are failures of course, as in everything else, but they are not more than one in ten, and of these half at least are failures only so far as this, that the abscess has established a sinus, and that for some time after the tooth has been filled there is an occasional discharge of pus from this sinus; but the cause of the diseased condition is removed, there is little if any pain, and the discharge ceases after a time. The first treatment is a very simple matter. Percussion indicates a diseased condition outside the tooth—that is, in the periodontal membrane, and the cause is a decomposing pulp or some other putrescent matter in the pulp cavity. The tooth is generally decayed, so that a very slight excavation will open the pulp cavity and give vent to the poisonous gases and pus which are confined there, and when these find an outlet the pain ceases. Recognising the fact that alveolar abscess does not, and cannot, arise from a tooth which has a healthy pulp, it is obvious that an opening into the pulp cavity will be a painless operation, which, of course, extraction would not be, nor will extraction give relief so quickly as the simple treatment I have suggested. I do not mean to say that the soreness which was felt on pressure will immediately disappear; it will take time for that; but the intensity of the pain will be mitigated, the contents of the abscess will be evacuated through the roots of the tooth, and very quickly the tooth will be in a condition for further treatment, which will in most cases result in a radical cure of the tendency to abscess, and the tooth will be made useful and comfortable. The course of treatment is a series of antiseptic dressings in the roots to cleanse them from all putrescent matter, and then, as in the other case, filling them to the apex, for while abscess is first caused by toxic matter from the decomposing pulp, it is maintained and renewed by the filling up of the pulp cavity with pus and lymph, which in their turn pass through the same course of decomposition. This root treatment, however, is not available in temporary teeth after the sixth year,

as the process of absorption which is going on in the roots of these teeth will have so widened the apical foramina that a solid filling cannot be made, and is therefore worse than useless; but it is better to open the pulp cavity freely and leave it open, so as to allow free evacuation into the mouth and allow the tooth to decay gradually, as it will of course do, until nothing but the roots remain, than to deprive the child of a masticator at once.

The child needs masticators quite as much as the adult; but, more than this, I am certain that it is almost an impossibility to extract the temporary molar when it is in anything like full development without more or less displacement of the partially developed bicuspid which lies between the roots of the temporary molar. I am well aware that it has been said over and over again by writers who are recognised as authorities that the development of the alveolus of the bicuspids does not depend on the retention of the temporary teeth; but what does that matter if the partially calcified crown of the bicuspid is so displaced that the further development goes on with the tooth in a transverse or a horizontal position? I have in my possession models, of the upper and lower jaws of a boy of ten years and a half of age, whose temporary molars and two canines were all taken out while in almost perfect development, and the gums are shrunken like those of an old man, with not the slightest indication of a bicuspid appearing for the next five years. I often see cases where some of the temporary molars have been removed, but I confess I do not often see cases of such wholesale premature extraction.

Alveolar abscess may arise from a putrescent pulp in a tooth which is not decayed at all, but which has some time been displaced by accident so as to sever the nerve and bloodvessels at the apical foramen. This happens, especially with front teeth, from a fall, from a blow, from many chances in athletic games; and often enough the tooth may be comfortable for months after the accident, so that no one thinks of connecting the present pain with what happened so long ago, but by drilling into the pulp cavity the poisonous gases and the pus are evacuated, and

the tooth can be made as useful as the others. In all cases after a front tooth has been loosened by an accident it should be watched carefully for a few months to see if any change of color takes place, and if so the pulp cavity should be opened at once.

Pyorrhœa alveolaris may cause something very like alveolar abscess, and yet the pulp of the tooth will retain its vitality; but in this case the disease commences at the neck of the tooth and proceeds towards the apex of the root, which is exactly the reverse of what happens when there is a putrescent pulp. In these cases, although relief will be given by a thorough cleansing of the root, by scraping, and by one or two applications of aromatic sulphuric acid, followed by soothing dressings, there is little chance of saving the tooth for more than a year or two.

In this paper I have only meant to indicate that there are means of relieving the ordinary forms of toothache, which will be far more merciful than extraction, to the patient, and which are so simple that any surgeon can make use of them, and at least, if he cannot complete the operation, he will have relieved present suffering, and left the tooth to be treated hands which have had more practice. But I do not by any means pretend to have exhausted the subject, or to have presented anything which will be new to dentists. I am told that surgeons do not learn these things from their text-books, and I hope I have shown them that there is something more interesting about teeth than extracting them.—*London Lancet.*

DENGUE OR INFLUENZA?

An interesting feature of the prevailing "Russian epidemic" which has attracted some attention, especially at the hands of the Paris physicians, to whom the characters of influenza, or *la grippe*, are so familiar, is the variation its symptoms have exhibited from those ordinarily present in the disease. Thus it is asserted that catarrhal characters have been notably slight, the predominant features of the few days' fever being muscular pains,

prostration, headache, and in some cases a scarlatiniform eruption. Now, it is pointed out that dengue, an affection hitherto almost confined to tropical climates, prevailed extensively in Syria last spring, has since occurred widely in Constantinople, and even been observed elsewhere in the south of Europe. This fact, added to the unusual features of the present epidemic, has given rise to the notion that perhaps it is really dengue, and not influenza, which has invaded the temperate zone and been modified by subjection to altered climatic conditions. At the Academy of Medicine on the 17th inst. M. Proust, in discussing two papers on the Syrian outbreak of dengue, contributed by M. Le Brun, declared that the present epidemic in Paris, although having some features in common with dengue, could not be regarded as being that disease, but that it is really influenza with pronounced nervous symptoms. He stated that dengue has never passed beyond the limits of 45° N. and 25° S. latitude. M. Rochard added that the characteristic eruption and articular pains of dengue were not exhibited by the sufferers from the prevailing epidemic, and M. Colin said that it resembled other epidemics of *la grippe*. M. Dujardin Beaumetz, however, thought there were several points of resemblance between the two affections, and that a hasty conclusion was to be deprecated; on the other hand, M. Brouardel held that dengue and influenza were as specifically distinct as typhoid and typhus. M. Bucquoy pointed to the analogies between the two, and seemed inclined to the view that the present epidemic is dengue modified by climatic conditions. The patients he had seen complained of muscular or articular pains, and presented redness of the palate and a scarlatiniform eruption on the chest. M. Bouchardt said that dengue is contagious, *la grippe* is not; and that the latter did not extend along the lines of commercial intercourse, but was apparently influenced by atmospheric conditions. M. Proust reasserted his opinion that the epidemic was not dengue, which at Constantinople was not modified by the cold season. He also said that the eruptions noted by M. Bucquoy had not been observed by others.

At the Medical Society of the Hospitals on the 18th M. Le-greux introduced the topic of the epidemic, and pointed out how it differed from classical influenza, catarrhal manifestations being exceptional, headache, ocular pain, nausea, colic, and fever chiefly marking it, and recovery following after two or three days in bed. He had seen some grave cases, and cited one of a lady in whom the pains in the head were so severe, with nausea, delirium, rapid pulse, and temperature of 102.2° F., that meningitis was feared. The symptoms disappeared in forty-eight hours under treatment by antipyrin. In children he had observed coryza or bronchitis, or more often gastro intestinal catarrh. In every case the duration was shorter than ordinary influenza. M. Sevestre had noticed two types. In some, the minority, there were the features of ordinary influenza. Others were marked by the absence of catarrh of the respiratory passages, by intense pains in the head, eyes, and loins, and by fever. In one-third of his cases there was an eruption on the face resembling either scarlatina or measles, and recalling dengue. In terming such cases *la grippe* the usual meaning of the term was altered. The speakers concurred as to the value of antipyrin. A writer in *Le Progres Medical* (Dec. 21st), under the heading "Grippe ou Dengue," in which the outbreak among the *employes* at the Louvre at the end of November is stated to be the starting point of the epidemic that rapidly spread through many large establishments in Paris, refers to the descriptions given by Dr. Le Brun of the Beyrout epidemic of dengue, and suggests that both influenza and dengue are now prevailing in Paris. In particular the characters of an outbreak observed in a large scholastic institution in Paris are noted as closely approximating to the latter affection—sudden onset with frontal headache or orbital pain, difficulty in walking, pain in the limbs, &c; rarely cough, but slight tickling in the throat; many having constipation, nausea, or even vomiting. The throat was congested, tongue dry, pyrexia high (102.2° to 104°), and by the end of the first day a scarlatiniform rash, which became more like that of measles on the second day, when

the fever slightly abated. The rash faded on the third or fourth day, when the patients were nearly recovered. In some cases, where the patients got up too soon, there were relapses of fever, with rigors and headache, but no fresh eruption. Desquamation was not observed in any case. In the *Gazette Medicale* (Dec. 21st), Dr. de Ranse points to the discussions at the above-named Paris societies as justifying the hesitation at first expressed by the Russian physicians before concluding that the epidemic at St. Petersburg was influenza. He propounds three questions, which, shortly put, are: 1. Are influenza and dengue distinct diseases or only the same disease modified by climate? 2. May they develop simultaneously in epidemic state in the same region and combine to form a hybrid affection? 3. If entirely distinct, is the present epidemic influenza or dengue? In answering these questions, and concluding in favor of influenza, he rightly says that the exceptional occurrence of some cases showing a rash is not enough to ally it with dengue, and believes that some of the earlier recorded epidemics of influenza would show as marked an absence of pulmonary catarrh as is now presented.—*London Lancet*.

A CASE OF DYSENTERY TREATED BY INJECTIONS OF SULPHATE OF COPPER.

BY W. EASBY, M.D.

The case narrated in THE LANCET of Aug. 31st by Mr. Hepburn reminds me of a case where injections of sulphate of copper were most successful. The patient, J. O. —, aged fifty, was a thin, spare man. He lived in the Cambridgeshire Fens, and in his young days had suffered from ague. The water-supply to his house was very bad; the usual drinking water was rain water kept in a wooden tub, and when this ran short that from the dykes was used. I first saw him on Dec. 31st, 1876; he had all the symptoms of a smart attack of dysentery; these continued for a week, when he was much better. On Jan. 14th, 1887, he had a relapse, but improved by the 20th. On the 21st I

heard he was worse, and was passing a lot of blood, and had much tenesmus. I at once prepared an injection of sulphate of copper, 10 gr.; tincture of opium, 1 dr.; and 4 oz. of water. On reaching the house I found him lying in a small pool of blood. He informed me this had been going on all night, and the tenesmus was unbearable, bringing away blood and mucus. I well oiled a large long gum-elastic catheter, and with a finger in the rectum passed it as far into the bowel as it would go, which was at least fifteen inches; through this the copper solution was injected from a small brass syringe; it caused no pain; and in the evening the tenesmus was relieved, and very little blood had passed. On the 22nd he was decidedly better, but more blood in the stools than I liked, so the injection was repeated, and again on the 23rd; and from this date he recovered rapidly. My treatment prior to the copper injection was bismuth, gallic acid, a full dose of powdered ipecacuanha; but nothing gave such rapid and permanent relief as the copper and opium. The diet was purely milk. I have not had such a bad case as this in an adult since, but in children several; and here the same treatment proved successful.

STERILITY IN WOMEN—ITS ETIOLOGY AND TREATMENT.

A paper read before the Mississippi Valley Medical Society at Evansville, Ind., Sept. 10, 1889, by Dr. E. S. McKEE, of Cincinnati.

The author found the subject a difficult one. He thought the most common cause of sterility was intra-uterine disease, and chronic endometritis its general manifestation. Inflammations of the pelvic peritoneum and of the parametria or their consequences are a frequent origin. Three things must be determined: Are spermatozoa in the semen? Do they get into the utero cervical canal? Do the vaginal secretions poison the spermatozoa? Sterility in man must be eliminated before seeking the causes of childless marriages in the wife. Gross claims that one out of six sterile marriages are the fault of the husband, and Kehrer claims one-third,

and the cause of the barrenness was gonorrhœa. The habits of the wealthy diminish fertility, while those of the poorer classes seem to favor it. The injurious effect of excessive fat in women as regards childbearing is generally admitted. The prospects of offspring will depend more on the menses than the flesh, amenorrhœic fat women being usually sterile. The prevalence of spasmodic dysmenorrhœa among sterile women, about two out of five cases, leads to a belief that this condition has some influence upon sterility. Gonorrhœa is an important factor. The reflux of semen is not so important a cause as supposed; the mucous discharge of the glands of Cowper and Duverney are often mistaken for semen. A Chicago professor has found in that city that the hair on the mons veneris of sterile women is straight. He does not advise curling the hair as a cure for sterility, however. Sexual incompatibility is well known to exist.

SEE (C.) ON IODIDE OF POTASSIUM AS A CARDIAC TONIC.—The author has found that the iodides of potassium and sodium have very different actions and cannot be substituted one for the other. The potassium, does while the sodium does not, act on the heart and vessels. If from 15 to 45 grains of the iodide of potassium are injected into the veins of a dog, there is noticed first an *alkaline period*, in which the pulse becomes rapid and the arterial tension is raised; and second, an *iodic period*, during which the arterial pressure diminishes; with the iodide of sodium there is no alkaline period. In the alkaline stage there is constriction of the vessels, while in the iodic stage there is vascular dilatation. The potassium salt is, then, with digitalis, a permanent cardiac tonic. From a therapeutic point of view the author considers the drug contra-indicated in all nervous affections, among which he includes exophthalmic goitre, in which disease the pneumogastric nerve is parietic. He gives with success the iodide of potassium in fatty heart, in coronary sclerosis, in over-acting heart, in angina pectoris, and in the irregular heart of the aged.—*La France Medicale*.

THE NORTHERN LANCET.

THE PANDEMIC OF INFLUENZA.

There is no doubt, notwithstanding the sage professional opinions we read in the dailies, that La Grippe has caught many of Winnipeg's citizens. Fortunately our natural surroundings are such that with timely precautions and early yielding, instead of fighting against its embrace, the unpleasant grip usually relaxes its hold in four or five days. Of all epidemics that of influenza is the most ubiquitous; and not only does it subject mankind to its ravages, but acts in a very similar manner on horses and dogs, as well as on domestic fowls. The symptoms of this catarrhal affection of the respiratory and intestinal tract are too well known to require further mention. Fortunately their extreme severity in many cases, and their entire disorganizing effect are no indications of a serious result, as except in old age, constitutions debilitated by previous disease, and young delicate children, the prognosis is in all cases favorable. Seifert supposes the influenza germ to be a particular chain forming micrococcus. The epidemic usually appears in northern latitudes in the cold season, and in tropical countries in the summer months. The first epidemic of the kind noted in England occurred in 1173. Russia has generally been the initial point of the disease, but the epidemic of 1757 commenced in North America, gradually making its way eastward, invading England and Scotland in the September of 1758. We read in some papers that an outbreak of cholera may be expected during the coming summer and autumn, but such predictions are as absurd as they are mischievous and groundless. The treatment of influenza should be expectant and symptomatic, and it is very necessary to disinfect all handkerchiefs in use by those who are affected.

INFLUENZA has attacked several local medical men, a circumstance of which the public are kept well posted by the reporters. These peripatetic and most

inquisitive of their genus seem to have no regard to the sacred privacy of domestic life, its sorrows or its joys, but dish up tit bits of gossip for the matutinal delectation of the readers of their several journals, with details so minute as almost to include the number of handkerchiefs used by Dr. A. and the amount of sneezing got through by Dr. B.; and, while still battling with the grim spectre, appears the obituary of one whose friends and relatives were still hoping that God's mercy might be extended to the sufferer and that he might be spared to the sorrowing relatives and friends surrounding his couch of pain. Surely this lifting the veil of private life to the public gaze is being carried too far, and matters more generally interesting and less personally offensive might be found for the columns of the dailies.

DEATH OF DR. R. B. FERGUSON.

It is with feelings of very deep regret we chronicle the death of Dr. Robert Buchanan Fergusson, which occurred at the Clarendon Hotel in this city on the 11th ult. at the comparatively early age of 51 years. Up to the date of his fatal illness. Dr. Fergusson was in the enjoyment of robust health, but a neglected cold, which developed into pneumonia, deprived our profession of one of its most skilful and respected members. Dr. Fergusson was born in Canada, of Scotch parentage, at Lanark, in Ontario, graduating at Queen's College, Kingston, and for some time practiced in Perth. He removed to Winnipeg in 1879, and soon acquired a large practice. He was one of the active promoters in establishing the Winnipeg General Hospital and the Manitoba Faculty of Medicine, occupying the position of Surgeon to the Hospital, and Professor of Midwifery in the Medical College, to both of which Institutions his demise will prove a very serious loss. Somewhat brusque in manner, strong in his likes and dislikes, an honest or kinder heart did not beat; and all who enjoyed his intimacy held for him a warm and sincere friendship. He was a man of great force of character, entering on

all he undertook with vigor and determination; strong in his opinions, when once formed it was difficult to change him, though he was ever open to conviction. Dr. Fergusson possessed in an eminent degree all those attributes which combine to make a successful practitioner of medicine, and, with that ripening experience on which he was just entering, which no tongue can convey, or book teach, he would, in those years to come which he might have looked forward to enjoying, have made for himself a widely extended reputation. But it was God's will to remove our friend from amongst us, and deprive his sorrowing widow of a loving husband, and his orphaned children of a fond affectionate parent. Though their grief must necessarily be the most poignant, it will be a melancholy consolation for them to know that many are truly mourning with them in their sad bereavement. The numerous and beautiful floral offerings, tributes of affection and esteem, which covered and surrounded his last narrow home, abundantly testified to the warm friendship that he enjoyed, and the sorrow evoked by his unexpected demise.

WE also regret to record the death of Dr. Fafard, Surgeon to St. Boniface Hospital and Professor of Botany in Manitoba Medical College, which occurred at his residence in St. Boniface on the 12th ult.

MISCELLANEOUS.

ANTIPIRYN IN THE TREATMENT OF NOCTURNAL INCONTINENCE OF URINE.—(Perret and Devic, *Rev. D. Gen. de Therap.*) The first case in which it was tried was that of a child $4\frac{1}{2}$ years of age, who was in the habit of passing water in bed several times during the night. Belladonna and Bromides were given without any improvement. From May 20 to 27 he was given twenty-two grains of antipyrin, half at 6 p.m., and the rest at 8. During this period of time the child did not wet the bed at all. The treatment was repeated off and on for some time, and ultimately proved completely successful.

Another child, eight years of age, subject to the same infirmity, was given a half a drachm of antipyrin, half 6 p.m., and the rest at 9 p.m., and the incontinence ceased with the same promptness as in the other case.—*London Med. Recorder.*

IODOFORM AS A HÆMOSTATIC.—Dr. Michailoff publishes some observations on the use of iodoform as a hæmstatic. He claims good results in hæmoptysis, metrorrhagia, hæmaturia, and hæmorrhoidal bleeding. He gives it in all cases of hæmoptysis with Doyer's powder, five times a day. He combines it sometimes with tannin; and in hæmaturia uses it in conjunction with bicarbonate of soda.—*Medizinski Prigled, Sophia.*

TANNIN is warmly recommended in cases of severe burns and scalds, it quickly relieves pain and causes rapid healing. It is applied in 5 per cent. solution by allowing the solution to trickle over the sore; this is repeated whenever the bandage is changed; a cooling ointment is applied after the tannin solution.—*Pharm. Ztg., 1889.* (See also, *Amer. Jour. Phar., 1886, p. 611.*)

CHLOROFORM IN LABOR.—(*Ibid.*)—It has generally been believed that any organic disease of the heart should prevent the accoucheur's employing chloroform in labor, but it has been pretty satisfactorily proven that there is more danger without the anæsthetic in such cases than with it: therefore do not regard organic cardiac trouble as preventing its use. The administration of chloroform should not be carried to complete anæsthesia; just enough should be given to modify the pain—not enough to produce unconsciousness. It is a pretty safe rule to pour a little chloroform on a sponge and give it to the patient herself to inhale a little whenever she feels the pain, the sponge dropping from her hand if she gets too much. The time for its use is at the beginning of the expulsive pains when they become severe, and its exhibition should cease immediately upon expulsion of the head. The chloroform should not only be given in those cases where the rigidity of the parts constitute a special indication, or in convulsions, where all physicians concede its

necessity, or in those cases where version can prevent embryotomy, but also in all cases of labor where there is very considerable amount of pain, or where the patient is nervous and irritable.

ATMOSPHERIC PRESSURE AS A CAUSE OF RETENTION OF THE PLACENTA.—Dr. J. M. Rodriguez explains a theory of Dr. P. Gavilan, of Durango, with regard to certain cases of retention of placenta by *atmospheric pressure*. He, in such a case, having introduced the hand into the uterus, found it impossible to loosen the borders of the placenta; so, with his fingers, he pierced the central part of it, when at once, before he had time to make traction, the after-birth lay loose in his hand. He thinks that when the edges of the placenta adhere too firmly, and traction, is made on the cord, a vacuum is formed in the centre; when the air enters, by introducing the finger, the placenta is expelled. Certain cases of Dr. Rodriguez's practice seem to confirm the theory. Some of the members present mentioned analogous cases which might be explained by this theory.—*Gaceta Medica*, City of Mexico.

PICQUE ON CONSTRUCTION OF A VAGINA BY AN AUTOPLASTIC PROCESS.—The patient was a girl of eighteen, with a normal vulva, no vagina, an infantile uterus, and without retention of the menses. The author created a vagina after the method of Amussat. He sought to remedy cicatricial contraction by slipping the mucous membrane of the vestibule upon the roof and the skin of the perineum upon the floor of the vagina. The results of the operation remained five months after operation.—*L'Union Med.*, Oct. 29th, 1889.

TREATMENT OF INGROWING TOE-NAIL.—There is no lack of suggestions for the treatment of this painful infirmity, but as none of them are absolutely reliable, one is disposed to welcome new-comers of avowable origin. Dr. Clemens, of Frankfort, recommends the use of tin-foil. After carefully washing the toe with soap and water, and then wiping the affected nail perfectly dry, he spreads a layer of tin-foil in such wise as to en-

velope the nail in its entirety. At the same time narrow strips of the foil are insinuated between the edge and the ulcerated flesh. The dressing is fixed *in situ* by means of a little yellow wax, and need not be changed oftener than once in three days. The foot should not be washed while the treatment is in progress, it being kept clean by rubbing with dry bran. The cure is rapid, even if the patient continues to walk about in ill-fitting boots, as most of Dr. Clemens' patients are reported to have done.—*Med. Press*, Nov. 6, 1889.

POST PARTUM HÆMORRHAGE.—Ed. in *Med. Era*.—Compression of the abdominal aorta through the uterus in post-partum hæmorrhage has resulted in prompt checking of the hæmorrhage. Insert the hand into the uterus, using antiseptic precautions. Five cases of hæmorrhage which did not yield under ordinary treatment were promptly checked under this procedure. The patients recovered with no untoward symptoms.

After post-partum hæmorrhage Gill recommends the substitution of rectal injections of saline solution in place of transfusion, or, rather, in those cases where the performance of transfusion is impossible from want of the necessary apparatus. He refers to a case in which he believes that life was saved by the employment of this method. He recommends that only two or three ounces of the fluid be injected at a time, and that the injections be repeated from ten to fifteen minutes, using a tepid solution, and, of course, employing auxiliary methods of relieving the existing shock to the system.

DISINFECTANT DENTIFRICE.—Protagiurleo gives the following: Alcohol of 40 per cent. 500; camphor, 10; salicylic acid, 20; benzoin, 50; clove stalks, 100; hypochlorite of lime, 50; essence of anis, 20; glycerin, 500. All of the substances except the hypochlorite and anis are placed in a strong, closed flask which is subjected in a water bath to 60° C. of heat for five hours, agitating occasionally. After macerating for eight days and filtering, the hypochlorite is added, when a further maceration of eight days is

given, when the anis is added and the preparation is finally filtered. The liquid should be put up in small blue or yellow phials. This preparation perfumes the mouth, whitens the teeth and frees the adherent tartar. It also hardens the gums and arrests gingival hemorrhages. For a mouthwash two teaspoonfuls are added to a quart of water.—*Furm Ital.; Boll. Ital.; Report de Phar., Oct.*

TYPHOID FEVER.—Dr. Yeo, of London, gives a tablespoonful every four hours of the following solution: Put one drachm of powdered chlorate of potash into an empty twelve-ounce bottle, add one drachm of strong hydrochloric acid; a greenish colored gas at once begins to come off, composed in part of chlorine. Keep the bottle stopped with the finger for a few minutes, until it has become filled with the gas, then add water, little by little, shaking up the water with the gas at each addition, until the bottle is nearly full. You will now have in the bottle a solution of chlorine, together with hydrochloric acid. To this solution I add sulphate of quinine in the proportion of two to three grains to the ounce, and a little syrup. Useful also in scarlatina maligna.

A CASE OF IRREDUCIBLE LUXATION OF THE HIP-JOINT TREATED BY OPERATION.—The patient, a young man, aged seventeen, had contracted his luxation one hundred and three days before admission to the hospital. Professor Bloch, of Copenhagen, performed resection after Langenbeck's method. The head was found almost entirely separated from the neck by a large fissure, and only connected with it by a small bridge of bone, the acetabulum being filled with fibroid tissue. The whole head was removed, and six weeks later the patient, who before the operation was only able to walk with great difficulty, had the free use of his limb, and nine months later he could walk long distances without any support and sit down comfortably. Shortening, four centimetres.—*Hospitals Tidende.*

CONGENITAL DEAFNESS: A CONTRIBUTION TO THE ETIOLOGY AND PATHOGENESIS OF DEAF-MUTISM.—This work is the result

of investigations based upon the literature of so called congenital deaf-mutism, and on clinical observations in Dr. W Meyer's clinic for ear diseases. The original material comprises altogether two hundred and ten cases of deaf mutism examined in the above-named clinic. Out of these only fifty-four cases could be considered as unquestionably congenital. Among the predisposing causes the author lays especial stress upon heredity and consanguinity of the parents. Among the members of the family of mutes born deaf there very often exist deaf-mutes; these latter seldom appear in the direct ascending line; more frequently they belong to the collateral branches of the family, but with greatest frequency among brothers and sisters of deaf-born children. On the other hand, common deafness is more often observed in the collateral branches of the family, it being rare in the direct line, and most frequent in the direct ascending lines. The author endeavors to ascribe this to ear diseases, which lead to common deafness, and finds corroborative evidence in the pathological changes found in post-mortem examinations of deaf-born, of which the author has gathered forty-six cases from ancient and modern literature, this being a much larger number than has hitherto been collected by other observers. Consanguinity of the parents is a factor of the greatest importance in congenital deafness, the author having found not less than twelve out of his fifty-four patients (22.2 per cent.) to be the offspring of consanguineous marriages, and thus proving the influence of intermarriage in the production of deaf-mutism. Congenital deaf-mutes have, as a rule, more hearing left than mutes with acquired deafness, and the prognosis of the former (though, of course, grave) is undoubtedly better than that of acquired deaf-mutism. The author ends with the conclusion that children born deaf should never be considered as incurable, unless a proper examination and treatment have been resorted to.—*Monog. by Holger Mygind, Copenhagen, 1888.*

ANTIFEBRIN IN INFLUENZA OF THE HORSE.—It may interest your readers to know that the form of influenza now so

prevalent amongst horses in London, and which appears very closely indeed to resemble the catarrhal epidemic on the continent, has in my hands yielded very markedly to the use of antifebrin. I mention this because I observe that some continental physicians strongly recommend antipyrin. As far as I know, these agents have not previously been used in veterinary practice; they appear, however, in the horse to be most valuable febrifuges, being capable of reducing the temperature as much as five degrees in from sixteen to twenty four hours. An opinion prevails amongst physicians that these medicines, if given freely, are attended with cardiac depression. So far as my observations have extended (and I have treated about 100 cases with antifebrin), in the horse, at all events, no ill effects follow provided that diffusible stimulants be given with the drug, and the latter be withheld on the temperature becoming normal. To show that antifebrin may be given liberally with safety, I may remark that in one extreme case I gave one drachm and a half every six hours for three days, although the pulse was at first very frequent (99) and weak (the standard in the horse being taken as 60.) No unpleasant symptoms followed except very slight diarrhoea, which apparently afforded the animal some relief. I could give you a more complete account, but having forwarded an article with cases recorded to the *Veterinarian*, I refer you to this if the subject is of sufficient importance. I feel justified in asserting that antifebrin is one of the best remedies for influenza in horses, that it may in equine patients be given without fear, and that very few deaths will result if good nursing and hygienic conditions are likewise brought to bear upon the patient.

—W. F. BARRETT, M.R.C.V.S.

PILLS OF TAR AND IODOFORM.—Negel gives the following formula for these pills which, he says, are well supported by phthisical patients: Iodoform, 3 gm.; vegetable tar, 15 gm.; extract of opium, 60 cgm.; make 120 pills. The writer states that the addition of 5 to 10 per cent. of tar to iodoform, perfectly deodorizes the latter.—*Revue de Phar.*, July.

ARTERIES FOR DRAINAGE TUBES.—At the late meeting of the American Surgical Association, Dr. S. H. Weeks showed some specimens of a new variety of absorbable drainage-tubes he has prepared. They are made from the arteries of the ox. The vessels are separated from their sheaths, and cut into appropriate lengths. They are first boiled in water for five minutes, then passed over glass rods of proper size. Subsequently they are immersed for ten minutes in corrosive sublimate solution (1 per cent.), and finally stored in alcohol (95 per cent.) They are said to be entirely unirritating, to act as efficient drains, and to be absorbed in about a week.

COLLODIUM.—Can be obtained perfectly transparent if it be agitated with carefully washed and ignited quartz sand; the effect is purely mechanical, the suspended particles with the sand forming a heavy gelatinous mass from which the clear collodium is easily decanted.—Kransfeld, *Phaz. Ztschr. f. Russl.*, 1889, 392.

TEETH-CLEANSER FOR DISCOLORED TEETH.—Make a stiff paste of powdered cuttle-fish bone with a four per cent. solution of hydrogen peroxide; apply by rubbing over the teeth and after a few minutes rinse with plenty of water. The teeth are cleansed in a few minutes without injury to the enamel.—*Oester. Zeitschr. f. Pharm.*, 1889, 304.

SENSE OF TASTE IN CRIMINALS.—The following note reproduced in the *Journal de la Sante* may be found interesting. Dr. S. Ottolenghi, a pupil of Professor Lombroso, has studied the sense of taste in criminals compared with that of other individuals. He says that in criminals the sense of taste is manifestly weak relatively to that of ordinary individuals; there is, again, a difference less marked between occasional delinquents, and those who are habitual or born delinquents. Female criminals have the sense of taste still more obtuse than men of the same category. The author concludes from these remarks that this diminution in the sense of taste in criminals depends on a defect in the cerebral cortex.

THE ADMINISTRATION OF CHLOROFORM.

—M. Dastre lately made a communication to the Societe de Biologie relative to the dangers of anæsthesia by the use of chloroform, and recalled that he had always prevented these dangers in dogs by preceding the administration of the chloroform with a subcutaneous injection of atropine associated with morphia. He remarked that death which occurs during anæsthesia is often due to an irritation of the pneumogastric ganglia, which produces arrest of the heart and death by syncope. The atropomorphinic injection has the effect of preventing the production of this excitation.

INCOMPATIBILITY OF CHLORATE OF POTASSIUM AND IODIDE OF IRON.—According to the *Boll. Farm. (Arch. de phar., July 5, 1888)*, the death of a child was caused by the iodine resulting from the decomposition of these salts. The iron precipitates in the form of a sesquioxide, and the iodine is completely eliminated in accordance with the following formula: $2\text{FeI}_2 \div \text{KClO}_3 = \text{Fe}_2\text{O}_3 \div \text{KCl} \div 4\text{I}$.

INTERNATIONAL CONGRESS OF MEDICAL JURISPRUDENCE.—A congress with this title is announced to meet in New York on June 4th next. It is to be held under the auspices of the Medico-Legal Society, but the following five papers are announced from other countries than the States—viz: Dr. C. Spadaro (Puglia, Italy), "Nouveau Procède pour la Recherche des Cristaux de l'Emine du Sang Humain"; Dr. Norman Kerr (London), on "Criminal Responsibility in Narcomania"; Mr. Connolly Norman (Ireland), on "Feigned Insanity"; Mr. A. Wood Renton (London), on "Medical Expectism in the Old World."

PINZONI (OF BOLOGNA) ON ERGOT IN CHILDREN.—The drug was administered, generally in the form of about two grammes of the powder daily, to ninety-one lying in patients. Seventy-nine similar cases were treated with ergot. After comparing the series, the author came to the following conclusions: Ergot has little or no influence on the temperature; at the most a slight rise is occasionally observed. It hastens the pulse a little, yet has no marked influence on the physiolog-

ical slackening of the pulse observed during the first days after delivery. The involution of the uterus, according to the author's researches, is either totally uninfluenced by ergot or slightly retarded. The escape of the lochia remains normal when the drug is given; but clots are more readily expelled. The lochia are seldom fetid when ergot is taken. Ergot delays the after-pains in primiparæ and lessens them when they have already commenced. The secretion of milk is retarded and lessened by ergot, and sometimes completely suppressed. Ergot seems, according to Dr. Pinzoni to be a prophylactic against puerperal fever, an indirect antiseptic agent. When infection had taken place, ergot appeared, on the other hand, to hasten the entrance of the virus into the circulation—*Br. Med. Jour., Aug. 10, 1889.*

LOCAL ANÆSTHESIA WITH SELTZER WATER.—Dr. Voituriez, (*J. de sci. med. de Lille*) recommends the use of siphons of seltzer water for this purpose, the jet being held at about ten centimeters from the region to be anæsthetized. He uses at first two or three bottles of the seltzer, which gives anæsthesia for four or five minutes, when a small additional quantity will suffice to prolong the effect.

THE LANCET, LONDON, AND THE HYDERABAD CHLOROFORM COMMISSION.—We have just received from Dr. Lauder Brunton the following telegram, which we print *verbatim*: "Four hundred and ninety dogs, horses, monkeys, goats, cats and rabbits used. One hundred and twenty with manometer. All records photographed. Numerous observations on every individual animal. Results most instructive. Danger from chloroform is asphyxia or overdose; none whatever heart direct." These results apparently indicate such a complete reversal of the view held by Dr. Lauder Brunton at the time he left England—that one of the dangers resulting from chloroform is death by stoppage of the heart—that the details of the experiments made by Dr. Brunton, and the reasons for the conclusions he has evidently arrived at, will be awaited with the greatest interest by the profession.