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THE

CANADIAN PRACTITIONER

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

EDITORS:

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☞ Business Management, - - THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.

TORONTO, NOVEMBER 16, 1889.

Original Communications.

HÆMATOMA OF THE STERNO-CLEIDO-MASTOID IN INFANTS.*

BY DR. ALBERT A. MACDONALD.

Though this condition does not give rise to symptoms of any great urgency, it should demand our attention to a greater extent than I believe it does.

The pathology of these so-called tumors of the sterno-mastoid must necessarily be difficult to elucidate, as it is so seldom that opportunities of *post mortem* investigation are offered. Recent publications have, however, made it clear that at least some of these cases occur at parturition, and that the swellings are due to local hæmorrhage into the sheath of the muscle, as the result of injury by traction or pressure. At least three-fourths of the cases have happened in breech presentations, where, doubtless, in order to free the after coming head, undue traction has been made.

The muscles of the semi-asphyxiated infant being flabby and toneless, some portions are probably torn, and blood readily oozes out of the minute vessels, collecting beneath the sheath of the muscle, and giving rise to the blood tumor, which is soft at first, but in the course of a few days, becoming organized, presents the hardened lump which is commonly pointed out days or even weeks after the birth of the child During this period I have not noticed any symptoms of urgency, but it is afterwards that the little one has at least a decided appearance of inconvenience and perhaps even of suffering. The right is more commonly affected than the left sterno-mastoid, and the upper than the lower portion of the muscle Usually the tumor is about the size of a pigeon's egg, and slightly elongated in form.

Sometimes more than one enlargement may appear in the same muscle. It is rare to find both sides affected. In some instances the greater part of the muscle has undergone a change, and it feels enlarged and hard to the touch, somewhat shortened so that the head and face are drawn, giving to the infant the expression so characteristic of wry-neck. Pain is not experienced on pressure, but rather a general inconvenience; whilst the peculiar expression of the child with the presence of the tumor is a source of anxiety to the parents. These cases are more common in the old country than here, and amongst the poorer classes than those who are in more comfortable circumstances. As a rule they recover without treatment, though their disappearance may be accelerated by the exhibition and application of suitable remedies. They commonly last for some months, and for a long time afterwards a hardened cicatrix may be felt in the seat of the tumor. Though I believe, as before mentioned, that in the majority of instances this condition is the result of violence during the process of delivery, I believe

*Abstracts from a paper read before the Toronto Medical Society, Oct. 29, 1889.

that a condition very closely resembling it may arise from occult causes, whilst the fœtus is still in utero undergoing the changes due to its development.

In such cases, however, the condition is more allied to the faulty development which produces such deformities as valgus. There is a difference which I wish to mark.

Where a true hæmatoma is found the sterno-mastoid is alone the muscle affected, whilst in congenital wry-neck other muscles, as the trapezius and scaleni, are implicated.

Of the more noticeable influences which may combine to give rise to this latter condition, may be mentioned the spasmodic, paralytic, rheumatic, syphilitic, strumous, pressure in utero and mal-nutrition. Whilst it is true that wry-neck co-exists at times with a spastic condition of the muscles involved, it is unlikely that muscular spasm would give rise to a tumor, and the deformity under consideration. Where paralytic influences are present they act quite as much by lowering the nutrition as by disturbing the bal ance between the muscles at fault.

In syphilis and the strumous diathesis we have what would seem to be a most reasonable cause for the deformity, and indeed the tumors under consideration have been termed gummata by some authors.

Pressure in utero seems also to offer a solution of the way in which these deformities may be brought about, and some cases have been noted in which the quantity of liquor amnii was decidedly below the normal. Many observers, especially amongst the Germans, incline to the belief that pressure upon the fœtus in utero is a potent cause for club foot. Reasoning against spastic causes that as the deformity is met with during the early periods of gestation, the poorly developed muscles could have but little effect in pulling the bones out of place. Whilst deficient liquor amnii, a condition not altogether uncommon, might probably tend to produce the deformity. If then pressure can produce valgus, why not wry-neck ?

Of true hæmatoma of the sterno-mastoid I have only met with five cases in all my professional experience. One or two of these may be of interest.

L., the infant of parents of whom the mother is a nervous woman, of large frame, but not very strong constitution, having had mitral stenosis for some years. The father had an attack of syphilis of a mild type of which he was as completely cured as possible, no symptoms having appeared for more than a year prior to his marriage. His health was, to all appearance, perfect. After a normal period of gestation, and at the termination of a natural labour, in which the head came in the O.L.A. position, where there was no traction upon the neck, this infant was born. I examined the child with care, as I was anxious lest some lesion of a syphilitic nature might be found, but I did not notice anything wrong, and it was two weeks before my attention was called by the nurse to the lump in the neck. I examined the tumor which was ovoid in form and fully an inch and a half in length. It caused some shortening of the muscle, and had the feeling of a gumma. I ordered daily inunction of ungt. hydg. fort. over the hardened part with the result that the tumor commenced to disappear, and by the time the child was nine months old hardly a trace of it could be found, and the child held its head in a normal position. The little one has grown and thrived, and is as healthy as any child to-day, having escaped most of the ailments so common to babyhood and the early periods of dentition. Now from the appearance, feeling, and history of this case, I believe it was one of true hæmatoma of the sterno-cleido-mastoid, though I must say that I cannot lay it to any undue traction upon the neck by the accoucheur

Another case. M , the infant of healthy parents who had other children in whom no deformity had appeared, was found to have an enlargement of the left sterno-mastoid. This was brought to my notice on about the fifth day, when it was found to commence near the sternal attachment of the sterno-mastoid, and to extend in cylindro-conical shape to within an inch of the upper end of the muscle. It was quite hard, and pressure did not give rise to any evidence of pain or uneasiness. The muscle was somewhat shortened and the head was drawn towards the affected side, the face being held somewhat upward and in the opposite direction. In this case, the infant being otherwise strong, healthy, and evidently well nourished, and there being an absence of any strumous taint in either of the

parents, I resolved that there should be no treatment; so, telling the mother that all would be right in a few months, I allowed nature to take its course, with the result that the hardness, swelling, and deformity gradually disappeared, so that at the end of four months no trace of the tumor could be found, and the head was carried in an erect manner, being turned as readily towards one side as towards the other.

I think that these two cases are somewhat typical, and in neither instance could I attribute the deformity to traction or roughness in delivery.

Without wishing to tire you by the relation of cases I would cite at least another which, however, had not such a happy termination.

A. was born after a normal period of gestation and an easy labour. I cannot describe the early appearance, as the case did not come under my notice for some years. When it did, the head was drawn down and towards the left side, with the usual expression produced by wry-neck. Many things had been tried for the relief of the deformity, with only slight benefit. After division of the sternal origin of the muscle partial relief was obtained, but the case seemed to require something more, and it was only after regular application of the galvanic current to the muscle, the anode being applied to the upper extremity, the cathode to the lower, and the opposing muscle being treated with labile applications of the Faradic current, whilst all the muscles of the neck were treated by massage, and the system at large by alterative tonics, cod liver oil, and such measures for the advancement of the general nutrition that improvement of a steady character was brought about.

The chief importance which seems to me to attach itself to a consideration of cases such as we have been occupied with, is that we should be induced to take more care of the neck during delivery. We must remember that it contains parts which are most valuable to the infant, and that many of these parts are of a delicate nature and easily injured by rough handling.

We should be most careful in all cases, but more especially in those of the after coming head, and I believe it to be a good plan in such cases always to have the forceps at hand and ready for application at a moment's notice.

SOME PRACTICAL POINTS IN GYNÆCOLOGY AND ABDOMINAL SURGERY.*

BY DR. HOLFORD WALKER.

Ectopic or extra-uterine gestation, a condition under certain circumstances, above all others where prompt recognition by the general practitioner is called for, and early surgical interference necessary, in order to save an otherwise hopeless case.

Where a desquamative condition of the fallopian tubes, in consequence of a previous attack of salpingitis, or some other cause, which, depriving them of their cilia, permits the ovum to become arrested and impregnated during its passage through the tube, we have a condition that I fear is of more frequent occurrence than the majority of the medical profession is aware of. Such being the case it is most desirable that a subject of such grave importance should be freely discussed at both the local and general medical societies, as by that means the practitioner will be better able to diagnose the condition.

I refer more particularly to what is termed *primary rupture* into the peritoneal cavity, directly from the fallopian tube; and also what is termed *secondary rupture*, being from between the folds of the broad ligament, also into the peritoneal cavity. On the hypothesis that all ectopic gestations are originally tubal, "with the possible exception of the impregnation of the ovum in its vesicle before it leaves the ovary,' and the primary rupture takes place, either (1) from the tube directly into the abdominal cavity, or (2) from the tube into and between the folds of the *broad ligament*, where in the latter event gestation may go on until full term.

What is termed *secondary* rupture, takes place when it does occur, from between the folds of the *broad ligament*, also into the *abdominal cavity* and accounts for those cases of supposed purely abdominal gestations, whereas in reality, tubal gestation has first taken place, then *primary rupture* into the *broad ligament* followed by *secondary rupture* into the abdominal cavity, where the child may also continue to exist until full term.

*Read at the meeting of the Ontario Medical Association.

In the majority of these cases of ruptured tubal pregnancies, if not in all, there seems to exist a Providential warning note, for as a rule the first rupture and hemorrhage is not fatal, it is the subsequent attack or attacks to which the patient succumbs, but all the more urgent need for the physician to recognize the condition, and have it removed before it is too late.

It is not my object in a paper of this description, to refer to the various authors and their various opinions regarding this important condition, but rather to give the practical points of interest to date on the subject, and arouse an interest for full discussion, and greater attention on the part of the profession towards it.

As regards the diagnosis of ectopic gestation before primary rupture, there are certain symptoms, which may lead the physician to further investigation of the case, when consulted on the subject, but unfortunately in the great majority of cases, the first intimation he has of the case, is being called suddenly, and finding his patient in a more or less collapsed condition, suffering severe pain, with tender and swollen abdomen, blanched face. Enquires will elicit the information that the attack came on very suddenly, without any known cause, that she has been pregnant for the past few weeks. Examination will reveal a mass on either side of the uterus, and the os not presenting that peculiar soft velvet feeling so characteristic of normal pregnancy. With these symptoms presenting, take warning, as it is nature's aura for *ruptured ectopic gestation*, and secure assistance before a repetition of the scene is enacted.

But when consulted before the period of rupture the patient tells you she thinks she is pregnant, but has some peculiar and distressing symptoms which causes her to seek advice. She will complain of peculiar cramp-like pains in the groin and hypogastrium, occurring at frequent intervals, increasing in intensity with more or less faintness, menstruation may cease altogether, or more frequently vicarious discharges, and on enquiry it is found, either that the interval between marriage and the first impregnation is unusually long, or if the patient has already borne children, a period of sterility frequently precedes the ectopic gestation. She will most probably tell you of a previous attack of salpingitis, or as she will term it, inflammation of the bowels, following a natural labor, or an abortion, producing a diseased condition of the appendages; dysmenorrhœa will invariably have been complained of, occurring a day or two previous to the flow, and during the first day, a very characteristic sign of tubal trouble. With this history and symptoms an examination should be made, and if ectopic gestation exists, a mass will be found on either side of the uterus, which urgently calls for an exploratory incision, thus saving future complications, and consequent greater risk of life.

Another condition I would briefly refer to is that calling for what is known as *Porro's* operation, to take the place of *craniotomy* or cæsarian section. I do not propose to enter into the pros and cons of this momentous question, but to state shortly, that I consider it the operation of the future, where the pelvis from deformity or otherwise, is so reduced in diameter as not to permit the passage of the child without resorting to some capital operation for its delivery, when such a condition exists, I declare absolutely in favor of abdominal action, and removal of the *uterus*, and thus save both mother and child, and not only that, but at the same time save the mother from a repetition of this untoward event.

One very great reason in favor of the procedure, is its simplicity; the majority of physicians can perform it, *or ought to be able to*, and with appliances that are always at hand, or to be had, "whereas Sænger's modification of cæsarian section is an operation not adapted to, nor by any means of easy performance by the general practitioner." There is another more weighty reason still, what moral or legal right has the physician to take the life of a human being deliberately? I fear we do not justly realize the fearful responsibility assumed, at the time or afterwards, but hide ourselves under the cloak of professional privileges, and age-long custom, but ere many years have come and gone, I foresee that a very strong term will be applied to designate the man and physician, who will so far forget, or fail to realize his legal or moral position as to deliberately take the life of a human being by performing craniotomy.

I speak perhaps in strong terms, but it is by having matters forcibly brought to our notice, that we are induced to give them that attention to which they are justly entitled.

The past cannot be recalled, and the degree

of personal responsibility is no doubt lessened by the example and sanction of our predecessors, but in the future, when light and knowledge, and the great advance of abdominal surgery, are duly recognized, and the fearful responsibility realized, the man who undertakes to perform craniotomy, will be what is sometimes termed brave, but rather callous to universal opinion or personal remorse.

The appliances necessary when one is not in possession of the usual instruments required in performing hysterectomy, are three or four compression forceps, a piece of rubber tubing of a quarter inch thickness, two long pins, known as ladies' hat pins, a scalpel, three or four sponges, needle and thread, half an ounce of saturated solution of glycerine with ferri-perchlor., and some ordinary lint or absorbent cotton.

Open the abdomen to the extent of four or five inches, slip the rubber tubing over and around the neck of the uterus, making a tight single tie, and hand to an assistant to hold, *open the uterus*, remove the child, and pull the uterus through the abdominal opening, tie the rubber tube with a second knot tight, cut off the uterus, pass the two needles at right angles through the pedicle, at the same time through the tubing to hold all in place, the pins will prevent the pedicle from slipping back into the abdomen, sew up the abdominal wound, close to and leaving the pedicle in the lowest angle of it, then trim the pedicle of all superfluous tissue, and tuck small pieces of lint, two or three inches square, under the needles and around the stump, pour the solution of glycerine and iron over the stump, and cover with pieces of dry lint, and apply a bandage. If cleanliness is carefully observed, your patient will, in all probability, make an uninterrupted recovery, and you will have the satisfaction of having saved both *mother and child.*

Of course the mortality will depend to a great extent on the early recognitition by the physician of the necessity of an operation, before the exhaustion of the patient, or contusion of the parts in vain attempts at instrumental delivery.

Another disease or condition to which I would briefly draw your attention, one that proves very intractable and tries the patience of the physician to the utmost in vain attempts to afford permanent relief to his patient, is a form of dysmenorrhœa associated with an *infantile* condition of the *uterus.*

The history and symptoms of this condition are usually very characteristic. Menstruation as a rule is delayed in its onset, and ceases earlier in life than usual, frequently at 30, during the active menstrual period, the discharge is generally more or less irregular and scanty, the most severe pain occurring for some days before and during the period, and even between periods the patient experiences more or less severe pain of a neuralgic nature. On examination the educated finger can immediately detect the condition, the cervix frequently being no larger and often smaller than the end of the little finger, and the fundus in proportion, in some instances the cervix will be found normal while the fundus and appendages are infantile. Usually the pain is so severe and protracted that for two weeks during each month, the patient is almost, and in many instances totally, incapacitated for work, or in the higher walks of life, where there is no necessity for work, the patient during her active menstrual period passes one-half of her existence in bed or on the sofa, passing from time to time, from the care of one physician to another, one and all failing to afford at best more than temporary relief, the patient soon relapsing to a worse state than the first, until in many instances life becomes an intolerable burden.

Of course where the patient enjoys every home comfort, and can partake of absolute rest when occasion requires, there is not the same demand for radical treatment, as in the case of the girl who has to depend on her daily work for her daily bread. In the latter instance it is our bounden duty when other means have been tried in vain, to recommend the removal of the appendages, by which means if the menopause is produced, the patient secures good health again, and in a position to earn her daily bread in comfort.

In the case of the well-to-do patient, as I said before, there is not the same urgent necessity for radical interference, but the circumstances of the case should be fully explained, and then it is entirely optional for the patient, either to undergo the necessary operation, or continue to suffer.

Mr. Tait as also Dr. Savage, of Birmingham, have given this subject a great deal of attention of late years; experience teaching them that

where this condition of *infantile uterus* exists, removal of the appendages alone promises to afford permanent relief. The benefit resulting was most marked in cases I saw operated upon.

Previous to operation in the cases I saw, no diseased condition could be detected in the appendages after a careful examination, but on their removal an abnormal condition to a greater or less degree was found to account in a measure for the suffering. Although other instances occurred in both the above surgeons' experience, where nothing abnormal was found, but the results were equally brilliant in restoring the patient to health.

Some may argue that the condition does not warrant the operation; that opinion you will find as a rule to be advanced by either the man who always has and always will oppose the operation under almost any circumstances, or the man who has yet to experience a typical case of the condition referred to; for the latter's conversion to the procedure, I would only ask his experiencing three short months of the suffering endured by these unfortunates, he would urgently cry for help under any circumstances likely to afford relief. For the conversion of the former I would say the less you stir him up the better for the advancement of abdominal surgery in general and the welfare of unfortunate sufferers in particular.

As a rule sterility occurs in those cases where the infantile condition of the uterus exists, and thus the moral argument against the operation has not the same weight as under other circumstances, but on the other hand in these cases after marriage the suffering is even greater than before, and being now an established fact that the sexual appetite is not lessened by the operation but in many instances increased, is another argument in favor of its performance, even after marriage.

Some will tell you that they can cure the condition by dilatation of the cervix, others by equally futile methods. In answer I can only suggest that they have entirely mistaken the condition for something much more amenable to local treatment. Mr. Tait and Dr. Savage have given a thorough trial to electric and other stem pessaries and dilatation with negative results in each and every instance, and their experience is very great, as we all know.

Selections.

THE NON-TUBERCULAR AND NON-CARDIAC HÆMOPTYSIS OF ELDERLY PERSONS.

BY SIR ANDREW CLARK, BART., M.D.

Many years ago, when examining the evidence of the arrestment of phthisis and endeavoring to determine the conditions in which it occurred, I was struck with the large numbers of cases of hæmoptysis occurring in elderly persons who were at the time and remained afterwards free from signs of pulmonary tuberculosis or of structural disease of the heart. Being in those days completely influenced in my views of hæmoptysis by the teaching of Dr. Walshe, I ascribed every case of pulmonary hæmorrhage in which there was no heart disease or aneurysm, or malignant growth, to tubercular disease of the lung. Perhaps I carried to an extreme issue the opinions of this distinguished master; at any rate, I must confess that the consequences were not satisfactory for the patients or for me. At last, however, there occurred in the wards of the London Hospital a case of fatal hæmoptysis which not only made plain the error of my views, but revealed a cause, hitherto, I believe, unnoticed, of pulmonary hæmorrhage. The patient, a man between fifty and sixty years of age, was admitted for an attack for subacute bronchitis. He had been for many years the subject of a moderate progressive osteo-arthritis, and during the last four or five winters had suffered from severe bronchial catarrh. The attack from which the patient suffered on admission was of the ordinary character; there were signs of some congestion at the posterior bases and of emphysema of the front parts of both lungs, but nothing was found to suggest the existence of tubercular disease. The heart and bloodvessels were sound, there was only moderate fever. The patient was placed upon a light diet and treated with alkalies, alterative aperients, and counter-irritants to the chest. About a fortnight after admission the patient began to cough up blood in small quantities at short intervals, and in spite of all that could be done according to the approved therapeutical teaching of the time—in spite of

*Selection from a paper read at the Medical Society of London.

absolute rest, the strictest regulation of supplies, the application of ice to the chest, and the liberal use of various astringents—the bleeding persisted, and within a week the man died. The post-mortem revealed to the naked eye little that was unusual and nothing that was expected. The heart, the larger vessels, and the arterial valves were free from obvious structural change. The bronchial mucous membrane almost everywhere was swollen, congested, violet-colored, and coated with a muco-purulent secretion. The anterior parts of both lungs were pale, [illegible], and emphysematous, and curious patches of emphysema surrounded by hæmorrhagic extravasations were noticed in the back and lower parts of both lungs, which were loaded with blood. Nowhere could there be discovered the smallest evidence of tubercular disease, of any malignant growth, or of any sort of coarse structural change which could account for fatal hæmorrhage. A most minute examination carried out with the aid of the microscope brought plainly to light two important facts. The first was that the seat of the hæmorrhage was in the immediate neighborhood of the emphysematous patches, and the second was that the minute vessels, the terminal arteries for the most part, were in those localities always diseased. And finally, it appeared in the highest degree probable that there existed a direct casual relationship between the condition of the bloodvessels, the emphysema, and the hæmorrhage. For wherever there was an emphysematous patch there was a diseased artery; wherever the artery was much diseased the capillaries and venus radicles were also affected; and generally, although not always, where the terminal artery was obstructed and degenerating there was adjacent hæmorrhage. Through the observation of these facts and their relations I was led to conclude that the order of events issuing in hæmorrhage arose and proceeded in the following way. I inferred that the initial visible movement in the malady had been some minute structural change in the terminal branch of the pulmonary or of the bronchial artery, and in consequence of this there had been brought about a more or less complete obstruction of the supply of blood through the territory involved; that following this there arose degeneration of the capillaries, and venous radicles determining a true atrophic emphysema, and that the integrity of the bloodvessels being thus impaired, the formation of thrombi or recurrent condition of pressure had brought about the hæmorrhage which ended in death.

Now arose the cardinal question presented by this case, and necessary to be answered if any fresh knowledge were to be derived from it: What was the intimate nature of the structural vascular changes to which I have adverted? There were two ways of replying to this question, each was distinct in itself, and the one which was most regarded was of the least importance. The small question was, What were the visible characters of the structural alterations in the bloodvessels? The large and crucial question was, What was the nature of the primitive dynamic changes, and which alone gave them form and meaning? In them and not in the vascular changes lay the importance of the case. The structural changes discovered in the affected bloodvessels were limited to nuclear proliferation in the middle coat, and an amorphous and hyaline infiltration of it and of the intima. When I endeavored to determine the significance of these changes, and for this purpose studied the life history of the case, when I saw that the patient had been for years an arthitic, that he had suffered on many occasions from many of the constitutional manifestations of this diathesis, and that the structural changes in the pulmonary bloodvessels were akin in character to those which were found in the diseased articulations, I permitted myself to conclude that the malady was of an arthritic nature, and that I had seen and dealt with a case of what might be called without serious scientific impropriety, "arthritic hæmoptysis."

Some seven years ago Sir William Jenner, Dr. Wilson Fox, and I were summoned together to consult about a lady suffering from an incoercible hæmoptysis. She was a Jewish lady over sixty years of age, very stout, very "rheumatic," and always ailing. She had nodular finger joints, frequently recurring bronchial asthma, and occasional outbreaks of either eczema or of urticaria. Ten days before our visit, when suffering from an ordinary catarrh without accompanying fever, the patient began to cough up blood, and had continued to do so in small quantities at intervals of three or four hours since. The patient had a somewhat large heart, but there was no

murmur, and there was no evidence of systemic arterial disease. Within the previous two days the pulse had become quick and frequent, and the temperature had risen to close upon 100°. In the lungs there were signs of generalised bronchial catarrh, of emphysema, and of basic congestion. The patient complained of frequent cough, of great oppression of chest, and of growing difficulty in expectorating. She had, furthermore, a loaded tongue, thirst, loss of appetite, a swollen liver, and all the signs of a gastro-enteric catarrh. She had been carefully treated by absolute rest, fluid food, ice to the chest, and in succession by lead, gallic acid, and hypodermic injection of ergotin. After full discussion, it was determined that another method of treatment should be tried. The patient was ordered to have a light and rather dry diet, to be sparing in the use of liquids, to discontinue the ice, to have a calomel pill at night, followed by a saline cathartic on the succeeding morning, and to take an alkaline mixture with ammonia between meals twice a day. Within thirty-six hours the bleeding ceased, and the patient made a speedy and complete recovery. About a year and a half ago the patient consulted me at my house for subacute rheumatic arthritis. She told me that since she saw me first she had had one attack of bleeding, and that it was quickly cured by calomel and salines.

About six years ago I was summoned to meet Mr. MacLaren in consultation about the case of a solicitor who had been suffering from an obstinately recurring hæmoptysis of small amount. The patient was over sixty years of age, had been always delicate and often suffered from incomplete attacks of what was considered to be rheumatic gout. He had rimmed finger-joints, patches of dry eczema, and occasional nervous headaches. A few weeks before our consultation he had contracted a feverish bronchial catarrh and was confined to the house. After a fortnight's cold he began to have some oppression of chest and to be short breathed. This was followed by a small hæmoptysis which gave relief, but the hæmoptysis recurred, and at our consultation there was no sign of its cessation. The patient had no fever and only a slight hurry of circulation. There was a general bronchial catarrh, the fore parts of the lung were emphysematous, and there was some basic congestion, greater on the right side than on the left. The tongue was furred. There was anorexia with some thirst. The bowels were inadequately relieved, and the urine was pale and of low density, but free from albumen. The patient was directed to rest and keep warm, to live upon a light, semi-solid diet, to be sparing in the use of liquids, to be freely counter-irritated over the chest, to have a succession of small doses of calomel at bedtime, supplemented by saline aperients in the morning, and to take between meals, twice or thrice in the day, a mixture containing iodide of potassium, bicarbonate of potassium, and ammonia. This treatment was not particularly agreeable to the patient, who had medical views of his own. Nevertheless, it was adopted, and appeared so far successful that within four days of its adoption the hæmorrhage had ceased. I heard of the patient from a relative some months ago, and I was told, although he led a too sedentary life, he was well and at work.

I conclude with a statement of the propositions which I have framed out of the results of my own inquiries. These propositions are as follows:

1. That there occurs in elderly persons, free from ordinary diseases of the heart and lungs, a form of hæmoptysis arising out of minute structural alterations in the terminal bloodvessels of the lung.

2. That these vascular alterations occur in persons of the arthritic diathesis, resemble the vascular alterations found in osteo-arthritic articulations, and are themselves of an arthritic nature.

3. That although sometimes leading to a fatal issue, this variety of hæmoptysis usually subsides without the supervention of any coarse anatomical lesion of either the heart or the lungs.

4. That when present this variety of hæmorrhage is aggravated or maintained by the frequent administration of large doses of strong astringents, and by an unrestricted indulgence in liquids to allay the thirst which the astringents create.

5. That the treatment which appears at present to be the most successful in this variety of hæmoptysis consists in diet and quiet, in the restricted use of liquids, and the stilling of cough; in calomel and salines, in the use of alkalies, with iodide of potassium, and in frequently renewed counter-irritation.

TREATMENT OF THE PERINEUM DURING LABOR.

BY LUCY WAITE, M.D., IN *Clinique*.

Every accoucheur decides, early in his practice as to his methodof treating the perineum, and if under his method he has a measure of success, it is a difficult matter to convince him that there is a better. The first question to decide is whether or no the perineum shall be manipulated at all. Some of our leading obstetricians have put themselves on record as opposed to all forms of manipulation, classing them under the odious title of meddlesome midwifery. It seems to me that, keeping in mind the two objects to be gained—the prevention of too rapid delivery of the head, and the favoring, as far as possible, the minimum pressure on the posterior pelvic floor—skilled manipulation of the head and perineum cannot fail to aid in guiding the head safely through the narrow canal which it is obliged to pass.

I am a convert to the German method as practiced in the hospitals of Drs. Sparth and Braun, of Vienna. In brief the *modus operandi* in vogue in those hospitals, is as follows: The normal case of confinement is under the care of a midwife in training. It is her duty to watch the progress of the case, and on the bulging of the perineum, the patient is drawn to the edge of the bed, and turned upon her left side. The limbs have been previously wrapped in sheets. An assistant sits on the edge of the bed and supports the right limb, so as to raise it up and off of the arm of the operator. The operator takes her position at the back of the patient, passing the left hand over the right limb and between the thighs, and presses back the oncoming head with the fingers of the left hand. The ball of the right hand covers the anus, the thumb being placed on one side of the perineum and the fingers on the other. The central perineum is thus left in sight between the thumb and first finger, and is at no time subjected to pressure. In this position the head is under perfect control, lying between the two hands of the operator. With the right foot raised upon a stool or round of a chair and the elbow of the right arm resting against the right knee, the operator is in a position to use to the best advantage all the strength he possesses. Given this position of both patient and operator, the delivery of the head without laceration of the perineum, in any case which can reasonably be called normal, becomes a matter of strength, patience and judgment.

The head is really delivered between the pains. During pain the head is crowded back by the fingers into the vagina, allowed to advance only enough to put the perineum slightly more on the stretch than after the last pain, and between the pains the head is pushed by the ball of the right hand very gently upward and forward, away from the pelvic floor, and under the pubic arch. The head is practically rolled out between the two hands.

The perineum is thus stretched, line by line, and the head must be large and the perineum indeed tough which cannot be managed in this way, if sufficient time is taken.

The rules of the hospital require the attending midwife, if she has any suspicions that she is not going to be able to manage the case successfully, to summon the head midwife. The one in this position during my stay in the hospital had held it for thirty years, and was a most accomplished accoucheur. I have seen her deliver a large head when the perineum was stretched as thin as tissue paper, and the features of the child plainly visible through it. In such hands the manipulations become a work of art. As the thin membrane passes over the nose and chin, the assistants unconsciously catch their breath, and cannot believe that the perineum is saved. The delivery of the shoulders must be managed with the same skill, or all has been in vain. If the shoulders do not of themselves turn into the antero posterior axis of the canal, they are quickly turned, and the shoulder, pressing upon the perineum, delivered first, the other follows, and the second stage of labor is completed.

There are cases which even the skilled fingers of the over-madam, as she is called, cannot successfully manipulate, and it becomes her duty, when she sees a threatened rupture, to summon the house surgeon, who immediately performs episotomy. This is done by one cut made to the side from within out, from one-half to an inch, according to the judgment of the operator.

The immediate operation is made, in all cases, and the patient leaves the hospital with a sound perineum. No anæsthetics are used in normal cases, and no lubricants of any kind. In fact,

it would be impossible to manipulate the perineum in this way if the parts were more slippery than they must be under the natural lubricating fluids secreted at this time. A large reduction in the per cent. of lacerations is claimed for this method: 12 per cent. in all cases, as opposed to 15 to 40 per cent. under other methods.

When the forceps are used in head presentations, the patient is delivered on the back, the same general method being used, the forceps taking the place of the left hand.—*Archives of Gyn. and Obstet.*

DILATATION OF THE CERVIX UTERI FOR CHRONIC ENDOMETRITIS.

BY W. GILL WYLIE, M.D.,

Professor of Gynæcology at the New York Polyclinic and Hospital.

Gentlemen,—This patient is thirty-five years of age and has been married eleven years. She has no children, but had one miscarriage three months after marriage. She complains of constant pain in the back on the left side of a bearing-down character.

Many of the cases that at this clinic come here with trouble due to sepsis from miscarriage or labor, and they go about until they finally develop a low form of metritis. All such cases that follow a miscarriage or labor are unquestionably due to sepsis, and when this fact is better understood than it is at present we will have less disease of this nature to treat.

The uterus of this patient seems to be more or less moveable. The moment I touch the fundus with my probe she complains of great pain. I can therefore say this woman has chronic endometritis.

My treatment of chronic endometritis is first to determine its exact location, whether it is confined to the uterus alone or whether both the uterus and tubes are involved. If the uterus is moveable you may be sure that there is no disease of the tubes or uterus of any consequence, for when there are no adhesions there is no disease as a rule. Having ascertained the fact that the seat of the trouble is in the uterus, I wait until five or six days after menstruation and wash out the vagina with a 1:2000 solution of bichloride, and then pass the sound up to find out the exact size of the trouble. If there is no trouble in the uterus the sound will pass to the extent of two and one-half inches, and will give rise to no pain or hæmorrhage on the part of the patient when you touch the lining membrane of the fundus. If there is pain or hæmorrhage be assured there is some trouble there. Having cleansed the vagina I then proceed to dilate. The object of dilatation is mainly to secure drainage, and it is strange that this, the most important factor in the treatment of endometritis, is entirely overlooked in the text-books. Everyone knows how important it is to treat a cavity plugged up with thick tenacious mucus by drainage. Then having secured dilatation you can curette the mucous membrane thoroughly. After that I generally make an application of pure carbolic acid to the parts. By this simple method of treatment you can hope to cure your patient in a short time. By this means also I do away with the use of cauteries, caustics, or strong acids. By employing any of these agents you will make a scar, and the woman will suffer more severely from the scar at the menopause than from the original disease. As chronic endometritis is frequently the cause of dysmenorrhœa and sterility I use the same mode of treatment for these two forms of disease.—*Internat. Jour. of Surg.*

WHAT DRESSING SHALL LIE NEXT THE WOUND?

BY ROBERT T. MORRIS, M.D., NEW YORK.

The worst type of dressing is represented by vaselin or oils spread upon lint or upon any textile fabric, because the oleaginous material mingles with exuded lymph and serum and prevents organization, and because new epithelial and connective tissue cells become entangled in the fabric. This type of dressing is also bad because there is nothing in its make-up to prevent decomposition of the exudates that nature intends to use for purposes of repair.

There are only two types of the perfect dressing. One of these is represented by an iodoform covering for small wounds. The iodoform forms with lymph a thin form of coagulum that is not readily penetrated by micro-organisms, and even when a few are at work beneath it, the

ptomaines which they produce are neutralized by the iodoform.

The best dressing is composed as follows: First a strip of sterilised Lister's protective oiled silk which is just large enough to cover the wound or the line of sutures. There is nothing that will take the place of Lister's protective. Gutta percha tissue will not answer, because it is absolutely waterproof and the skin beneath it becomes somewhat sodden. Spun glass is as objectionable as gauze or cotton or textile fabrics, because it entangles new epithelial and connective tissue cells. It is almost impossible to obtain repair by the beautiful process of clot replacement, if we cover the clot with anything but Lister's protective. And in skin grafting we can use it to such advantage that it seems as though the failures with other dressings must be more frequent than they are. Under the smooth and slightly porous Lister's protective, epithelial cells shoot along over the surface of the wound unimpeded, and granulations in open wounds carry on the process of repair without the formation of pus under permanent antiseptic dressings. Over the Lister's protective we need a thick layer of absorbent gauze or cotton to draw away serum from the wound, and to dry it so that it is not a fit food for micro-organisms—*Inter. Jour. of Surg.*

CHLORATE OF POTASSIUM.—Dr. Coghill, in a paper read at the ninth International Medical Congress, confirmed the results of Wohler that chlorate of potassium is excreted in the urine unchanged and in the full amount ingested, and hence does not give off oxygen to the tissues. Nevertheless, besides its local uses, he finds it of value in preventing abortion, in all cases of pulmonary insufficiency, as phthisis, chronic pneumonia, and bronchitis, in anæmia, chlorosis, and general malnutrition. In addition it has an antiseptic action in diseases of the genito-urinary tract where there is suppuration or purulent or phosphatic urine.—*Brit. Med. Journal.*

DEATH OF A MEDICAL MAN FROM GLANDERS.—Our Vienna correspondent writes: A painful sensation has been caused here by the death of Dr. Hofmann von Wellenhof, assistant to Professor Grüber, in the Institute of Hygiene. Dr. Hofmann, who was only 26 years of age, had under his care a coachman who had contracted glanders from one of his horses. In preparing microscopic specimens of the bacilli of glanders Dr. Hofmann himself fell a victim to the disease, the infection, as was proved by *post-mortem* examination, having taken place through the mucous membrane of the respiratory passages. Death ensued very rapidly. It is said that another case of glanders has since come under observation in Professor von Schrotter's clinic.—*Brit. Med. Journal.*

TREATMENT OF GONORRHŒAL RHEUMATISM.—Dr. Buffet, of Elbeuf, has published some interesting observations on the course and treatment of gonorrhœal rheumatism, and concludes his paper with the following considerations: (1) Gonorrhœal rheumatism, often monoarticular, may affect several joints. (2) The small joints may be affected as well as the larger joints. (3) The malady may attack the tendinous sheaths, muscles, nerves, and cellular tissue. (4) The clinical difference with articular rheumatism consists in the absence of fever, of sweats, and in the fixity and the tenacity of the lesions. (5) The malady may terminate by anchylosis, suppuration, or by muscular atrophy. (6) The treatment reduces itself to placing the limbs in a good position, employing revulsion, massage, and electricity. The salicylate of soda and the anti-gonorrhœal medication have no action whatever.—*Med. Record.*

ALCOHOL IN DIPHTHERIA.—Edward R. Squibb, M.D., in *Col. and Clin. Record* (from discussion of Brooklyn Med. So.).—Alcohol is almost universally employed, generally as brandy or whiskey, but with two very distinct objects in view; the greater number of physicians using it in moderate quantities as a stimulant and a food to support the failing powers of their patients, and in the more exhausting stages of the disease, and always as an adjunct to other active treatment; but many used it in large quantities from the very onset of the disease, as a special, powerful antidote to the malignant poison of the disease, very much in the way that it is used in snake-bite. This treatment was pursued and strongly advocated by the late Dr. E. N. Chapman, of this city, up to the time of his death. Many have followed this use of alcohol, as the

principal element in treatment, with encouraging success, but not generally with the success of Dr. Chapman. Most of those who used alcohol in this way testified to the absence of any signs of intoxication when the disease was at all pronounced in degree; and any signs of intoxication or odor of alcohol on the breath were regarded as the limit of dosage. From six to twelve fluid ounces of brandy in the twenty-four hours were not infrequently used on children from six months to three years old, though in a larger part of a general experience much smaller quantities were required; but always alcohol from the first in liberal and frequent doses.

ABOUT BRAIN WEIGHT *(N. Y. Medical Record)*.—The average weight of the male brain is 49½ ounces—of the female, 44 ounces; a difference of over five ounces. Woman's brain has a higher specific gravity. The man has a arger brain in proportion to stature (Marshall), but woman's brain is larger in proportion to her weight. In 239 Russian brains (Buchstab) the ratio of body-weight to brain-weight was for the male as 38 to 1; for the female, 35 to 1. In woman the brain is shorter in the sagittal diameter, being from $6\frac{2}{5}$ to $6\frac{3}{5}$ inches in man, 6 to $6\frac{2}{5}$ inches in women (Huschka). The transverse and vertical diameters are more nearly equal in the two sexes. The difference between the weight of brain in man and woman increases with civilization, and is most marked in the Caucasian races. In Parisians this difference amounts to 222 grammes, or nearly seven ounces; in European nations generally, 163 grammes; in Hindoos, 120 grammes; in Australians, 103; in negroes, 82; in Chinese, 15. The greatest sexual difference as regards brain-weight is found at birth, when the female brain weighs 347 grammes, and the male 397, or about $\frac{1}{6}$ more, while the total weight of the male infant is about $\frac{1}{15}$ more than that of the female. The female brain begins to lose weight after the age of thirty, that of man not till ten or fifteen years later. The loss in women is very slight, however, and she keeps up a high brain-weight much later (till seventy) than man, so that in old age the difference in brain-weight is reduced to its minimum, or a little over three ounces.

METHOD OF ACQUIRING SYPHILIS—Dr. Bulkley, of New York, relates the following among a number of interesting cases:—Mr. Y. E., aged forty-five years, a gentleman with a grown-up family, came to me on account of a diffuse maculo-papular syphilide, with general adenopathy. He was perfectly positive that he had had no venereal exposure in any manner whatever, and was shocked as well as indignant at the suggestion that he had syphilis, he having only very recently cautioned his son against sexual transgressions. He had no sore on the penis, and I searched a long time to find the site of entry of the poison, for the eruption was manifestly of such a recent syphilis that I felt confident that the chancre, or its well-marked remains, must be still present. The lips and cavity of the mouth were examined in vain, as also the fingers and all other portions of the body where one might expect to find such a sore.

On questioning still further as to whether he had not some ulcerating spot on any portion of the body, he then called my attention to the sacral region, where he said that he had had a raw point for a number of weeks, which had been regarded as a simple ulcer, or as an epithelioma, by his family physician; it had, however, been suspected to be a chancre by a surgeon in another city, just before his visit, and just after the eruption appeared.

On examining the region, there was found an ulcer, deep in the fold of the nates, about an inch behind the anus, which, when the parts were separated, presented a round, ulcerated surface, about half an inch in diameter, sharply defined and with a grayish-white base; a distinct hardness could easily be made out on careful palpation.

The supposed and probable mode of infection was very interesting. He had long had some itching in that region, even for years, and at times a fissure would form along the crack of the nates, which he said existed also just before the new lesion developed. Some six weeks before his visit he had been in bathing, and, quite contrary to his usual custom, he had worn a strange suit of bathing clothes, and on account of the itching in that region he had rubbed and scratched the part vigorously through the bathing trowsers; the sore developed a few weeks after this single wearing of the public bathing suit at Coney

Island. It is easy to understand how a previous bather with mucous patches at the anus had left the secretions on the garment, and the exertions of rubbing the dampened cloth upon the fissure readily afforded the best possible opportunity for inoculation. The patient suffered from a pretty severe attack of syphilis.

IODIDE OF POTASSIUM A CARDIAC TONIC.—M. G. Sée has recently pointed out, before the Academy of Medicine, that iodide of potassium, far from being a depressant, is really a cardiac tonic, of almost equal value to digitalis or strophanthus in certain cases. Indeed, he says that iodide of potassium is the real cardiac drug (*vrai médicament du cœur*), since, when prescribed in cases of uncompensated mitral lesions or affections of the myocardium, it increases the cardiac power and raises vascular tension. Thus, by subsequently causing dilatation of the arterioles, it enables the heart to recover its power, and affords also better facilities for coronary circulation, thus improving the nutrition of the heart muscle.—*Lancet*, Oct. 19.

PYOSALPINX AND LAPAROTOMY.—In some clinical remarks recently published by Dr. Richelot in *La Semaine Médicale*, the indications and contraindications for laparotomy in pyosalpingitis are pointed out. These, he says, largely depend on the duration of the disease. A simple acute or subacute salpingitis may get well spontaneously or by simple means; whilst it is as much an abuse to remove an ovary simply because it is inflamed as it would be to castrate for orchitis. In his cases an interval of two years from the onset of symptoms is, *cæteris paribus*, allowed to elapse before removing organs which by that time would have become useless. Severity and constancy of pain, especially in laboring women, would perhaps justify interference. Of course, wherever the presence of pus can be found, surgical interference is called for, to obviate pelvic peritonitis and worse evils. The advice of some surgeons to wait for the spontaneous opening of the abscess is deprecated, and so is the proposition (in imitation of the usual course followed by nature in spontaneous cures) to operate through the vagina rather than directly through the peritoneum.—*Lancet*, Nov. 2.

CATHETERISM OF THE URETERS BY MEANS OF THE CYSTOSCOPE (Poirier, *La Presse Medicale.*)—Professor Sappey has brought before the Académie de Sciences de Paris a work of M. Poirier on this subject, which will probably render great service in the diagnosis of diseases of the kidney, especially as regards a unilateral affection, such as tumor. The essential condition of success in the operations which modern surgery undertakes on a kidney is that the opposite one should be really healthy. It is, therefore, of paramount importance, before commencing an ablation of a diseased kidney, to determine the condition and functional ability of its fellow. Unfortunately, this is most difficult, the indication furnished by exploration and the study of the physical signs being still insufficient. The best proceeding, therefore, is to draw off and analyse the separate products of the secretion of each kidney. This can be done with ease by illuminating the interior of the bladder by means of Nitze's cystoscope, or that of Boisseau and Rocher (which has a much larger field), and then searching for the openings of the ureters. Once found, a small sound, conducted through a special channel in the cystoscope, can be readily passed into them. Thus surgery is now in possession of the easy means it has hitherto wanted to dissociate the secretion of the two kidneys. It is evident, too, that this instrument, by dilating the terminal parts of the ureters, can facilitate the expulsion into the bladder of renal calculi.—*Med. Chron.*

THE RELATION OF SCROFULA TO TUBERCULOSIS.—Dr. E. Madigliano, of Pisa, has made some experimental investigations on rabbits and guinea pigs to determine whether scrofula and tuberculosis are exactly identical.

Koch, as is well known, discovered the presence of the tubercle bacillus in scrofulous formations, as well of those of tubercular origin. and from this it was assumed that there was no æstiological difference between the two, both being caused by the same bacillus. This belief in their identity went so far that certain investigators in this line made no distinction between the two in carrying out their experiments, using bacilli from a tubercular noduli at one time, and at another those from scrofulous products.

Madigliano took for granted the correctness of the results of numerous experiments on the lower animals with tubercular nodules, and therefore used only human scrofulous glands, after the methods of modern bacteriology. He inoculated 45 rabbits and guinea pigs with the scrofulous products of three different patients subcutaneously, in the peritoneal and pleural cavities. All of the guinea pigs developed tuberculosis, and the microscope revealed the presence of Koch's bacillus. The disease, however, developed much more slowly than if tubercular products had been inoculated, and the extent of tubercular infection was much less; for example, one of the guinea pigs gave birth to healthy, well-developed offspring four months after inoculation, and four more months passed before external signs of the disease appeared: three others remained in apparent health for a still longer period before the disease became manifest. All the rabbits inoculated remained healthy. Secondary inoculations were now made with material from the diseased guinea pigs. Madigliana's experiments led him to the following conclusions:

1. The virus of scrofula is really an attenuated form of the tubercular virus; the disease caused by it is much milder than that caused by real tubercular virus; and is harmless to rabbits.

2. After passing scrofulous virus through a generation of guinea pigs, its virulence becomes intensified to that of tuberculosis, and inoculations with it on rabbits are successful, while at first this property was entirely wanting.—*Deutsch. Med. Zeit., Weekly Med. Review.*

Therapeutic Notes.

FOR MIGRANE.—The following powder is recommended by Dr. Hammerschlag:

℞—Caffeinæ citratis,	grs. xv.
Phenacetini,	grs. xxx.
Sacch. alb.,	grs. xv.

Divid. in part aeq. No. x, ad caps. amyl.

Sig.—One capsule every two or three hours.

FOR TOOTHACHE.—The following liquid may be used to moisten a piece of cotton to be inserted into the cavity of a painful tooth to give relief:

R.—Extr. opii	aa grs. viij.
Bals. Peruv.	
Masticis	grs. xv.
Chloroform	℥ijss.

Therapeutische Monatshefte.—The American Jour. of the Med. Sciences.

A DRESSING FOR WOUNDS.

R.—Ungt. vaselini	40.0.
Olei eucalypti	10.0.

For Frostbites.

R.—Zinci sulph.	
Tannini	aa 2 0.
Aqua rosar	10.0.
Ung. emoll	20.00.

For Burns.

R.—Acidi borici	6.0.
Vaselini	
Emp. diachyli	aa 10.0.

To be used on linen.—*Centralblatt für Therapie.*

THE TREATMENT OF OPHTHALMIA NEONATORUM BY NAPHTHOL.—Buscariet *(Arch. de Tocologie)* reports the prophylactic treatment of ophthalmia at the Paris Charité as follows: For the mother, vaginal antiseptic douches during labor, bichloride of mercury 1 : 2,000, or B-naphthol 1 : 2,5000 or 1 · 5,000. The child's eyes are touched with solution of silver nitrate 1 : 100 or 1 : 50. For simple purulent ophthalmia the eyes are douched every hour by day, and every two or three hours by night with

B-naphthol	grs. 6.
Alcohol	℥ 3.
Distilled water	1 quart.

while the eyes are covered with compresses wet in the solution. In gonorrhœal ophthalmia the conjunctivæ are cauterized with silver nitrate solution 30 every twelve hours. Naphthol douches are 1 : 50 or continued, given by a fountain syringe, with compresses. — *The Amer. Jour. of the Med. Sciences.*

IN a recent case of *hysteria* at the Jefferson Medical College Clinic, Prof. DaCosta prescribed valerianate of zinc, gr. ij four times a day, and at night—

R. Chloral. hydrat.,	gr. x
Sodii bromid.,	gr. xx. M.

Rest, milk and a nourishing and stimulating diet were prescribed. During her monthly sickness she was directed to take apiol, gr. v, six globules in the twenty-four hours before and during menstruation, the zinc preparation being omitted at that time.

PROF. BARTHOLOW recommends the following for *bronchitis* resulting from insufficiency of secretion :—

R. Pilocarpin, hydrochlorat., gr. j
Picrotoxin., gr. ¼. M.
Fiant pil. xvj.
SIG.—One night and morning.

DR. JURIST, for a man with *tubercular laryngitis*, gave—

R. Creasoti, gr. xxx
Iodol, gr. xxx
Bismuth. subnitrat., gr. ix. M.
Fiant capsul. xv.
SIG.—One three times a day.

—*College and Clinical Record.*

USES OF BORACIC ACID.—Dr. Lebovicz, in the *Winer med. Presse*, narrates some uses to which he has put boracic acid.

1. Boracic acts antiseptically. Every soldier should carry one ounce of it in his overcoat pocket, and a handkerchief cut into two triangles for necessary bandages. Simply sprinkling a wound with finely powdered boracic acid suffices to insure rapid healing. This remedy being odorless and itself absorbing all odors, the author has used it advantageously in abscesses, ulcers of the feet, caries and necrosis of the bones, and in complicated fractures.

2. In anthrax and after the incision of furuncles it acts well when applied directly to the parts Forming furuncles should be painted several times daily with the following :

R.—Boracic acid, } aa equal parts.
Water, }

3. In burns, when the flesh is exposed, it is necessary to be careful with poisonous antiseptics. Boracic acid posseses the advantage of being non-poisonous. He covers the burnt surfaces with a boracic vaseline ointment in the proportion of one to five :

R.—Boracic acid (finely powdered) 20 parts.
Glycerine, - - 15 "
Mix and add,
Vaseline, - - 85 " —M.
Apply twice daily.

In severe burns with fever, the author combated the fever by the internal administration of the following :

R.—Boracic acid, - 4 parts.
Glycerine, - - 10 "
Water, - - 100 "
Syrup of poppies, - 25 " —M.
Sig.—A teaspoonful every two hours.

—*Brooklyn Med. Jour.*

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TORONTO, NOVEMBER 16, 1889.

ELECTRICITY IN GYNÆCOLOGY.

An interesting discussion on the estimate of the value of electricity in gynæcology took place at the recent meeting of the British Medical Association, held in Leeds. Dr. Playfair, the distinguished obstetrician of King's College, opened the discussion, and as he is one of the most enthusiastic of the recent converts to Apostoli's views, it was naturally expected that he would speak strongly in favor of the alleged brilliant results of electricity. Those who had such expectations were probably to a certain extent disappointed, because the conclusions arrived at by him were not very encouraging. They are as follows :

1. The continuous current is capable of effecting much good in certain selected cases, otherwise little amenable to treatment ; and its introduction is, therefore, a distinct gain to gynæcology.

2. It is an agent of considerable power, and, therefore, if rashly and injudiciously used, it is also capable of doing much harm.

3. It involves the use of a costly plant, and it is troublesome and tedious to work.

4. Since the proper selection of cases requires, moreover, much special knowledge and great care in the application of the remedy, it is never likely to come into very general use.

Dr. Ephraim Cutter, of New York, delivered an interesting address on the subject, in which he gave a summary of eighteen years' work in the treatment of uterine fibroids, and demonstated his methods of operating; but his statistics were so discouraging, showing as they did a mortality of 8 per cent., and a want of success in over half his cases, that his results are not likely to add materially to the number of converts.

Mr. Lawson, "that fellow from Birmingham," replied to Playfair and Cutter in his usual caustic style, and evidently considered that the treatment of uterine fibroids by electrolysis was worse than useless, because in addition to the dangers connected with this plan of treatment, much valuable time was likely to be wasted in thus delaying operative procedures.

Quite a number took what may be called a middle course, and claimed that electrolysis was well suited for a limited number of cases of uterine myomata, and not for the majority. It will be remembered that this was the gist of Dr. Sweetnam's contention last June, in his paper read before the Ontario Medical Association. Dr. Wm. Madden, of Dublin, emphasized the fact that in a large proportion of cases, no active treatment either by surgical or electrolytical methods was either necessary or justifiable, and he thought that when either method became necessary, the electrical should always be tried before resorting to the surgical.

MEDICAL PRACTICE IN 2000 A.D.

Edward Bellamy's socialistic novel, "Looking Backward," describes the status of practicing physicians in the year two thousand. By some necromancy the printers of the present day secured the carefully electric-written "copy," and thus is revealed to wondering minds the grand advances made in social conditions at the close of the next century. Mr. West, hypnotized in his subterranean sleeping chamber by Dr. Pillsbury, was not roused from his slumber until the flight of over one hundred years had taken place, when, through an accident, he was discovered and re-animated by the scientific attentions of Dr. Leete, whose conversations with the awakened sleeper have the freshness of novelty. The broad shoulders of the nation in that year to come bear like a feather the heavy burdens which crush the scientific aspirations of many physicians who are now forced to "take thought for the mor-ow." Then there will be no advertising quacks, no cutting of fees, no under competition, no club doctors, no discontented or cynical school men grasping for the plums which their seniors hold, for physicians retire from active professional labor at a comparatively early age, to spend the balance of their days in travel, recreation, and scientific investigations. "When you want a doctor," asks Mr. West, "do you simply apply to the proper bureau and take any one that may be sent?" "That rule would not work well in the case of physicians," replied Dr. Leete. "The good a physician can do a patient depends largely on his acquaintance with his constitutional tendencies and condition. The patient must be able, therefore, to call in a particular doctor, and he does so just as patients did in your day. The only difference is that instead of collecting his fee for himself, the doctor collects it for the nation by picking off the amount, according to a regular scale for medical attendance, from the patient's credit card."

"Well, if the fee is always the same, the good doctors are called constantly, and the poor doctors left in idleness?" "In the first place, if you will overlook the apparent conceit of the remark from a retired physician," replied Dr. Leete, "we have no poor doctors. Anyone who pleases to get a little smattering of medical terms is not now at liberty to practice on the bodies of citizens, as in your day. None but students who have passed the severe tests of the schools, and clearly proved their vocation, are permittted to practice. Then, too, you will observe that there is nowadays no attempt of doctors to build up their practices at the expense of other doctors. For the rest, the doctor has to render regular reports of his work to the Medical Bureau, and if he is not reasonably well employed, work is found for him."

CREMATION.

There is a general feeling of repugnance against cremation among people of all classes in all countries. Sanitary considerations, on the other hand, are leading many intelligent and thoughtful persons to the conclusion that it is very desirable in crowded cities, especially in the disposal of the bodies of those who die from such diseases as diphtheria, scarletina, phthisis, etc. Sir Spencer Wells shows that the practice of cremation is on the increase. In Rome 119 bodies were cremated in 1886, 155 in 1887, and over 200 in 1888. At the Woking Crematorium in England over 70 bodies have been cremated since the British Parliament authorized this method of the disposal of the dead.

THE TREATMENT OF TETANUS.

We are told by *Chambers's Journal* that Prof. Renzi, of Naples, has treated successfully several cases of tetanus, by absolute rest for the patient. This absolute rest does not mean simple release from labor, but includes rest for the several senses, as well as for the body. The ears of the patient are closed with wax, the room is darkened, and the floor is heavily carpeted. Every fifteen minutes the nurse enters with a shaded lantern to attend to his wants, and to adminster food such as eggs, milk, and other fluids. Nothing solid or requiring any attempt to masticate is given. Sedatives are administered as required to relieve pain. It is said this treatment shortens but little, if any, the length of the disease, but it lessens the force of the paroxysms, which gradually cease altogether.

NOTES.

A CHIROPODIST is to be attached to every German regiment.

500 Students have already registered this session at the Toronto General Hospital.

PROFESSOR JOHN WOOD has resigned his chair of Clinical Surgery at King's College Hospital.

DR. P. MÉNIÈRE has resigned the management of the *Gazette de Gynécologie*, published in Paris, France.

PROFESSOR EBERTH has become one of the editors of the *Fortschritte der Medicin* (founded by Friedländer).

PROFESSOR RICORD, of Paris, the father of modern syphilography, died in Paris, Oct. 22nd, 1889. He was an American by birth.

BRITISH MEDICAL ASSOCIATION.—It is probable that the 1891 meeting of the Association will be held in the ancient city of Bristol.

THE General Secretary of the Fourth International Medical Congress is Dr. Lassar, of Berlin, N.W. Karlstrasse 19, to whom all communications may be addressed.

THE budget of the German Imperial Home Office allots 80,000 marks as a contribution to the expenses of the Tenth International Medical Congress, to be held next year in Berlin.

TO ALLAY PAIN IN CASES OF ACUTE PLEURISY, Dr. Richard Otto (*Beil Klin Woch.*) advocates a partial compression of the thorax, by means of a broad band which tends to lessen the painful cough, and exercise an antiphlogistic action.

THE fire at the amphitheatre of the Paris Faculty of Medicine caused damage to the extent of about fifteen thousand dollars. One of Matout's pictures, representing Ambroise Parè applying a ligature for the first time, was valued at two thousand dollars.

THE TREATMENT OF CROUPOUS PNEUMONIA WITH CALOMEL is highly spoken of by an Italian physician in a recent number of *Lo Spermentale*. He uses it in combination with opium and regards the diarrhœa thus induced as exercising a favorable influence upon the course of the disease.

THE MASSEUR is to be found in this city by a whispered request to connect with telephone 1718. He will limber stiffened knees, rub the uterus in true French style, shake up the liver *a l'Anglaise*, induce the sphincters to relax, reduce the obese to shadowy forms, or give tonicity to worn-out genitalia, just as the doctor orders.

THE English Courts have lately decided that in a case "where a wound is given which, in the opinion of competent medical advisers, is dangerous, and the treatment which they adopt is the immediate cause of death, the party who inflicted the wound is criminally responsible." The decision was reached in the case in which it was sought to shift the responsibility from the person who inflicted the wound upon the doctors who sought to save the man's life.

DR. WILLIAM A. HAMMOND, of Washington, D. C., has a larger number of patients in his sanitarium for the treatment of mental and nervous diseases than ever before in the history of the institution, although he opened about a year ago with more than half the rooms occupied in his immense new building. He is conducting a number of experiments in the treatment of epilepsy by localizing the brain lesion, trephining and paring the convolutions, and will publish the result of his experiments in the near future.

NEW YORK POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL.—The Executive Committee of this institution have established a clinic for diseases of the rectum, to be under the care of Dr. Charles B. Kelsey, for the treatment of persons suffering from these diseases. Dr. Kelsey will also give clinical instruction in the Post-Graduate School on this subject. It is believed that this is the first institution in New York to organize such a clinic, which has been long needed. The high and wide reputation of Dr. Kelsey, founded upon years of special work, will afford a guarantee that the cases will be skillfully treated. Dr. J. Blair Gibbs will assist Dr. Kelsey in this new departure.

CURABILITY OF CIRRHOSIS OF THE LIVER.—According to Dr. H. Huchard (*Centralblatt für Therapie*), cirrhosis of the liver is especially amenable to treatment in the hypertrophic stage. The procedure which he adopted in such cases is as follows:

1. The use of iodide of potash or soda, but not in large doses as may be ordered for syphilitic cases, from five to twenty grains daily being quite sufficient.

2. Calomel in small doses, not more than one grain daily.

3. The judicious employment of a trochar when necessary to relieve the ascites, guarding, however, against a too free removal of the fluid at one sitting, particularly when there is a marked cachexia.

4. The importance of a milk diet is paramount. The patient must take at least from two to three quarts daily, a glass every two hours, not all at one drink but by mouthfuls in order to prevent the formation of large coagula. When there is constipation rhubarb may be employed, and if diarrhœa follows, lime water should be added to the milk. Pepsin may be used to advantage if so exclusive a dietary is not well tolerated, as may also various of the aromatic waters, or wine in small quantities when the milk becomes unpalatable.

HIGH TEMPERATURE IN CHILDREN.—W. J. Tyson, M.B., in the *Lancet* says: It is a well-known clinical fact how quickly the body temperature changes in children, and without this knowledge we should be constantly alarmed; yet I am afraid most of us do not really appreciate the above condition until we have been some years in practice. The most common cause is probably, I suppose, some form of error in diet, the offending food acting as an irritant upon the heat centre; another common cause is, I think, really a sunstroke; children in playing constantly throw off their caps and hats, and are exposed to the sun for many minutes. Doubtless there are other causes, but the above are the ones most commonly met with. The prevalent practice of people keeping their own clinical thermometers leads, in my experience, to the seeking of professional advice rather than the avoidance of it.

Hospital Reports.

FRACTURE OF THE FIFTH CERVICAL VERTEBRA.

Under the care of Prof. L. McFarlane. Reported at the Medical Society of Toronto University.

BY MR. M. M'FARLANE.

The case which I am about to report is one of a man sixty years of age, who, on the 12th of October was thrown from a butcher's cart,

landing upon his back, thereby sustaining injuries which gave rise to a series of interesting and peculiar symptoms.

Upon examining the patient, no visible injury could be noticed save a slight laceration of the left ear. The pupils were somewhat contracted, but responded readily to light, and accommodated themselves to distance. There was marked tenderness in the region of the fifth cervical vertebra, but as far as could be determined there was no displacement. Consciousness was suspended for a short time after the accident.

For the first two days there was paralysis of both arms and right leg. On the third day after the accident the patient began to recover control of the left arm, in so far as the flexors were concerned, but the extensors of the hand still remained paralyzed, giving rise to the condition known as "dropped hand." The right arm and leg remained paralyzed up to the time of his death.

For the first three days there was paralysis of the bladder, and at the end of this time it was noticed that the patient had lost control of the sphincter ani.

On the fifth day the pharyngeal muscles also became paralyzed.

For the first two days there was marked hyperæsthesia of the paralyzed limbs, after which tactile sensation appeared quite normal, and remained so, notwithstanding the fact that he complained of a sense of numbness, and at times a peculiar pricking sensation in the forearms and hands.

On the second day after the accident the patient was examined with a view of ascertaining his susceptibility to pain, and it was found that there was complete analgesia strictly confined to the parts previously spoken of as those in which he complained of numbness, namely, in both forearms and in both hands, which was demonstrated by the fact that a pin could be inserted without causing the slightest sensation of pain; yet in these same parts tactile sensation was not in the least impaired, the patient readily recognizing the slightest touch of the examiner's finger.

The symptoms as described above continued up to the time of his death, no other conditions ensuing, save that he was delirious the last two hours of his life.

On post-mortem examination made by Dr. W. H. B. Aikins, there was found a large effusion of blood over and beneath the right pectoral muscles, beneath the sternum, and over the surface of the pericardium.

There was also found a fracture of the sternum between the articulations of the first and second ribs, fracture of the first rib on the right side, as well as fracture of the laminæ of the fifth cervical vertebra, causing pressure on the cord, which upon examination showed a marked softening of the left side in the region of the fractured vertebra.

A contusion about half an inch in diameter was noticed on the posterior wall of the pharynx, on a level with the injuries sustained by the vertebral column.

When it is remembered that the fifth cervical spinal nerves (which give the arm its cutaneous supply), emerge from the vertebral column, between the fourth and fifth vertebræ, thus being above the seat of fracture, they would consequently escape injury, whereas the sixth, seventh, and eighth cervical and first dorsal nerves, which give the fore-arm its cutaneous supply, emerge from the vertebral column beneath the seat of faacture; it will to some extent explain why there should be analgesia in the fore-arm and hand, but not in the arm.

Book Notices.

A Treatise on the Science and Practice of Midwifery. By W. S. Playfair, M.D., LL.D., F.R.C.P., Professor of Obstetric Medicine in Kings College, etc. Philadelphia: Lea Brothers & Co.

This is the fifth American from the seventh English edition, with notes and additions by Dr. Robert P. Harris. Probably no text-book on midwifery is so well and favorably known in this country as that of Playfair's. Possibly some may be superior as far as the "science" of obstetrics is concerned, but certainly none as to the "art." Fortunately, however, it is both scientific and practical, and at the same time is written in such a pleasing style that a reader must of necessity reap as much pleasure as profit from its perusal.

The changes in the English edition as compared with the one immediately preceding are

few, and as a rule unimportant. The obstetric nomenclature decided on by a committee, with Simpson, of Edinburgh as President, appointed by the International Medical Congress, held at Washington in 1887 has been introduced. There are slight changes and additions in the chapters on generation and puerperal septicæmia. The American has introduced many new notes, especially in reference to Porro-Cæsarian operations.

Personal.

DR. C. E. STACEY has located at 396 College Street.

DR. F. BEEMER has opened an office on Queen Street East.

DR. WM. OSLER has taken an office at 209 West Monument Street, Baltimore.

DR. ROBERT W. REID has been appointed Professor of Anatomy in the University of Aberdeen.

Dr. D. C. MEYERS (Toronto University) has passed the required examination for the L. R. C. P., London.

DR. CHARLES B. NANCREDE, of Philadelphia, has been elected Professor of Surgery in the University of Michigan, Ann Arbor.

DR. E. A. HALL has removed from Paisley to 29 Avenue Street, Toronto. He will confine his practice to diseases of the eye, ear, throat, and nose.

DR. W. P. MANTON was elected President of the Detroit Gynæcological Society at its fifth annual meeting held Wednesday evening, Oct. 23rd, 1889.

DR. CHARLES P. CLARK, (Trin. Med. Coll., Tor. Univ., '89) has commenced practice in Buffalo, and has been appointed Demonstrator of Chemistry in the Niagara University Medical College.

Miscellaneous.

IT is said that children born deaf and dumb can now be taught to speak. M. Pinel has constructed an electric screen, by which the sound is propagated by the action of the voice on the walls of the upper palate and larynx and communicated to the brain, which by dint of education may be comprehended.—*Sanitary Volunteer.*

CREMATION FEES.—The Municipal Council has decided that a uniform fee of 50 francs will be charged for cremation at the furnaces in the cemetery of Père Lachaise, including the right to a compartment in the *Colombarium* for five years. The necessary expenses (decorations and ceremonial) vary from 200 francs down to nothing at all, according to the social position of the defunct. So far, fourteen bodies have been cremated — eight men, four women, a youth, and an infant. The duration of the proceeding was 50 minutes in a child of eight months, and nearly three hours in the case of an embalmed body, the average being 1¾ hours.—*Paris cor. Medical Press.*