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Original Communications.

REMARKS UPON ALEXANDER'S OPERATION.

BY A. LAPHORN SMITH, B.A., M.D., M.R.C.S.E.

Read before the Canada Medical Association at Quebec, August 19th, 1886.

The attempt to shorten the round ligaments in order to correct displacement of the uterus was made more than a century ago, but failed. The operation was revived about two years ago by Dr. Alexander of Liverpool, and it now bears his name. It is a very ingenious operation, perhaps one of the most so in surgery, and one, which if it really does what it is claimed to do, will prove a short road to the cure of a numerous class of cases, the treatment of which has heretofore been tedious and troublesome. At the same time as the operation is on its trial, it is a fair subject of criticism, and I have therefore chosen it as the topic of my paper.

Before discussing the pros and cons of the case, it would perhaps be better to give a description of the operation.

Preparatory treatment.—The patient must be confined to bed for several weeks, during which time the vagina should be tamponed with glycerine and cotton, interchanged with hot douche with the Davidson syringe. No patient can be considered suitable for the operation in whom the uterus is not entirely free from adhesion, and the tissues around the uterus free from tenderness. The uterus must be perfectly and freely movable. Dr. Alexander thus describes the operation after warning anyone who intends to operate, no matter what their stand-

ing, to perform the operation a few times on the dead subject if they wish to avoid disappointment. "The pubic spine is the first landmark, and can be felt by an intelligent finger under any depth of superincumbent fat. It does not make any matter whether the finger can feel the spine clearly or not, provided the primary incision is made within a reasonable distance of it, but there need be no serious difficulty in feeling it."

"From this an incision is to be made upwards and outwards, in the direction of the inguinal canal for one and a half to two or three inches, according to the fatness of the subject. A considerable thickness of subcutaneous fat is now to be cut through by subsequent incision, until the pearly glistening tendon of the internal oblique muscle is reached. Midway through the fatty tissue an aponeurosis sometimes appears so firm and smooth as to cause the operator to think he is deep enough; and if he begins to poke about here as I have done and seen done, it is little wonder no ligaments can there be found. The first stage of the operation consists in simply cutting down upon the tendon of the external oblique muscle, until it appears clear and shining at the bottom of the wound. If the operator succeeded in hitting the spine, the internal inguinal ring with the intercolumnar fibres crossing it, can also be seen. If not, the aperture made down to the muscles can be dragged over an extensive area by retractors, so that the region can be searched until the ring is found. The finger passed to the bottom of the wound may be used to detect the spine and the ring outside, the former by its hardness, the latter by its lessened resistance, compared with that of the aponeurosis around it. The

anatomical knowledge of the operator should always be equal to the recognition of these structures—that is the spine and internal abdominal ring. There are other apertures, as the aponeurosis, and a depression filled with fat below Poupart's ligaments that sometimes simulate the internal abdominal ring. Poupart's ligament below the intercolumnar fascia running across, and the spine at the inner side are sufficient landmarks. When in doubt a close deliberate survey of the position should be taken, and no gropings in the dark made, as these are certain to lead to failure."

"Having clearly isolated the internal abdominal wound, and tied or compressed any little vessels necessary to be attended to, the next step in the operation may be entered upon—viz. : to find the end of the ligament. The intercolumnar fascia, which is generally pushed forward by the fat and other structures beneath, is to be cut through over all the extent of the internal ring, and in the direction of the longest diameter, a nerve, some vessels, fat, some bands, and the round ligament springs out of the canal immediately."

"In stout people the quantity of fat conceals all the other structures. No grabbing at the mass is now to be practised, as some have recommended. By everting all the structures upwards the round ligament can be seen generally at the lowest part, and the white, easily distinguished, genital branch of the genito-crural nerve on its anterior surface and close to it. The ligament at this stage is more or less rounded in shape, sometimes rather delicate, but an always easily recognized *flesh* coloured structure, that might be easily destroyed by forceps rudely and blindly applied. Should the ligament seem very frail, or the operator be doubtful whether he has found it or not, he should take care not to displace the structures or to destroy them by searching or pulling. The best plan in such a case is to open up the inguinal canal a little, and then re-examine what he supposes to be the ligament. No difficulty in finding the ligament need thus ever be experienced, provided the operator knows what he is about. When the ligament is clearly identified the small nerve on its surface is to be cut through, without cutting any of the ligament, then gentle traction is to be made; either by the fingers or broad blunt pointed forceps. Care must be taken not to break the ligament by such traction. Bands will now be seen holding it to the neighboring structure. These should be cut through with scissors, the greatest caution being used to avoid

notching the ligament itself at the same time. With a little patience and perseverance the structure is so far free that all resistance is at an end, and it comes out as easily as if broken inside, as Dr. Mundé thought it was in his first case. As soon as it begins to peel out, and without drawing it out further, I leave that side, after covering the wound with a clean sponge, and operate on the opposite side. To do so my assistant and I change sides, so that I always stand on the side opposite to that on which I am operating. I can look thus better into the canal and draw the ligament more conveniently towards me; but of course the operation could be performed without this change of position. Having freed the opposite ligament, the difficulties of the operation are at an end, and the second stage is finished. I cannot on paper give with advantage a more detailed account of how to perform the second stage. It must be seen to be thoroughly understood. The third stage consists in placing the uterus in position by the sound, and pulling out the ligaments until they are felt to control that position. The replacing of the uterus is first performed, and it is held in position by a third assistant. The operator pulls out both ligaments almost simultaneously and gently, until the sound is felt to be slightly moved. He then hands both to the first assistant to hold, while with the curved needle, threaded with moderately fine catgut, he stitches each to both pillars of the ring by two sutures on each side, and thus secures the closure of the internal abdominal ring and the fixation of the ligament; without injuriously strangling the latter structure as it lies between. The assistant can now let go, the chafed ends of the ligaments are cut off, and the remainder stitched into the wound, by means of the sutures that close the incision. A fine drainage tube is inserted, and the wound washed out with carbolic or other lotion, before these sutures are tied. In hospital I perform the operation under the spray, and use gauze dressings. In private I dispense with the spray, and sometimes use boracic lint or absorbent cotton wool. I always drain as I believe it to be much safer, preventing any collection of pus or danger of interfascial suppuration. It may retard, in some cases the healing of the wound, but as I never allow my patients out of bed under three weeks this is not of much importance. Before the dressing is applied, in simple cases of retroversion and prolapse, I insert a Hodge pessary, and keep it in at

least during convalescence. When there is retroflexion as well I always insert a galvanic stem to keep the uterus straight during the healing of the wound. This I look upon as essential. By keeping the stem in for a month or so, the cure may be with certainty affected. An important question with regard to the third stage of the operation is, how far are the ligaments to be pulled out? My reply is to put the uterus in position and pull out the slack. The after-treatment of the operation consists in rest. The wound I generally dress on the second day, when I remove the tube, the small aperture left where they were removed being sufficient to maintain the necessary drainage in most cases. The ligaments should be allowed time to unite to the wound, to the pillars of the ring and to the canal, and for this purpose three weeks is quite short enough time. Several of my private patients have taken a longer rest and with benefit, as thus all the pelvic organs have become accustomed to their new position. The rest need not be in bed—a sofa and the sitting posture may vary the monotony of lying in bed; whilst sewing, reading, and other feminine arts may be indulged in after the first few days."

Such is the operation, and while all are agreed that it is a most ingenious one, there is a great difference of opinion among the highest authorities as to its harmlessness, efficiency and usefulness. I shall not attempt in the time at my disposal to recapitulate all that has been said about it by its leading friends and enemies. Neither shall I venture to say dogmatically that the operation may not prove a useful one. It has not been on its trial long enough for that. I shall merely endeavor to prove that Alexander's operation is not the scientific or rational treatment for displacements of the uterus. And I base my contention on several more or less well known facts.

1st. The round ligament is not really a ligament, but a bundle of muscular fibres derived from the transversalis and uterine muscle, and it follows, therefore, that it is capable of undergoing fatty degeneration, like any other muscle. This we know it does, for several of the very ablest operators who have performed the operation tell us that, in a certain number of cases, they found the so-called ligament so soft, so pliable, and so attenuated that they did not dare to draw on it; or when they did, it broke in their fingers. And these are just the cases where the uterus is likely to be displaced. In a fine, previously healthy subject dying

from some acute disease, we will find the round muscle well developed and easy to discover. But this kind of woman does not have displacements; or if she does, she does not know it, because the organ is healthy. So we may conclude that when the patient has neither ache or pain, we will find the pelvic organs and the abdominal walls in a healthy state, and there will be no trouble in reaching the round ligament and pulling it out, and cutting it off. While in a delicate, badly nourished woman, where the muscular system is ill-developed, and the circulation slow, you will find the uterus congested, heavy, displaced, and you will find the round ligaments thin and weak, if you find them at all.

Even supposing that you can easily find the round ligaments and cut half of them off, and so pull the uterus up into place, I maintain that it is not the right thing to do. If the round ligaments were really ligamentous structures it would be rational to do so; but they are small round muscles. Mr. Rainey has carefully studied their structure, and has shown that they are composed of striped or voluntary muscle. They arise by 3 fasciculi of tendinous fibres; the inner one from the tendon of the internal oblique and transversalis muscles near to the symphysis pubis, and the middle and external fasciculi from the inner and outer columns of the internal abdominal ring respectively, above Gimbernat's ligament. From these attachments the fibres pass backwards and outwards, soon becoming fleshy; they then unite into a rounded cord, which crosses in front of the epigastric artery and behind the lower tendon of the internal oblique and transversalis muscles. They then get between the layers of peritoneum, covering the broad ligament, along which they pass backwards, downwards and inwards, to the anterior and superior part of the uterus into which their fibres, spreading out a little, are inserted. Mr. Rainey, reasoning from the structure of the round ligaments, says that the presence of voluntary muscular fibres proves that they do not serve as mechanical supports to the uterus.

Sappey and Cruveillier say that the round ligaments are never on the stretch, and cannot resist displacements of the uterus. Some authors state that they tilt the uterus forwards during coition so as to deepen the seminal lake at the top of the vagina.

Judging from the origin and nerve supply of the round muscle, I should say that it was the counter-

part of the cremaster muscle in the male. Now we know that the cremaster, though not so often as the round muscle, sometimes becomes so weak or the testicles become so heavy that it is unable to support them, and then we have the testicles hanging down, a very painful condition of things. What do we do in these cases? Do we cut down on the cremaster and pull out an inch or two of it and cut it off? No, we ascertain why the testicles are dragging. If it is because they are permanently too heavy from some foreign growth, we remove it; or if only temporarily too heavy from acute or chronic inflammation we support them for the time with a suspensory bandage, until we can reduce the inflammation. But if the testicles are dragging because the cremaster muscles are in an atonic state, due to the patient's general health being run down, we should rather place him on a local and general tonic treatment. And just as the man's general health returns, so will his testicles rise and cease to pain him.

You all know how the testicles may drop at examination times. In fact pain in the testicle is almost as common as diarrhoea at that time. I have over and over again known the same thing to occur to the womb, in women, under similar circumstances. Many times women have come to me with prolapsus, stating that their womb had come down suddenly as the result of a fright; while several old stagers come to me regularly every summer, during the very warm weather, when everybody and everything seems relaxed, to have their womb replaced.

Should I perform Alexander's operation then? No, indeed I seldom ever introduce a pessary, any more than I would put splints on their legs to cure the weakness in their limbs, which nearly always accompanies the prolapsus in such cases. On the contrary I order then to remain in bed a few days with their hips higher than their heads, and I give them the strongest preparation of iron quinine and strychnine that their stomach will bear, good air, good food, and cold frictions to the abdomen.

Besides it must be remembered that the uterus is not held up by the round ligament alone, even if it is held up by it at all, which many anatomists deny. In fact, to treat displacements of the uterus scientifically, we should have a very clear idea of the manner in which it is held in place. Pardon me if I remind you that the supports of the uterus

are very varied. First of all there is the vagina which in a muscular well-developed woman is a strong tube or column alone capable of holding up a healthy uterus. But in the miserable weak woman of modern education it is very much weaker.

Again the vagina itself is supported by the perineum, and if there is rupture of the perineum, there will be prolapsus of the vagina, and, consequently, displacement of the uterus. Perhaps the two most important supports are the anterior or utero vesical and the posterior or utero sacral ligaments. The former contains bundles of fibrous tissue only, but no muscle, and hold the uterus fixed by its neck, to the bladder. The posterior or utero sacral ligaments extend from the lower part of the body of the uterus, to the other side of the sacrum, enveloped by peritoneum, and are composed of non striated muscular fibres which spring from the uterus. The experiments of Malgaigne would seem to prove that these ligaments constitute the principal obstacle to the falling of the womb towards the vulva. When traction is made on the cervix these ligaments are immediately seen to be tightened, and when they are divided the uterus sensibly drops, but it is soon arrested by the broad ligaments and the resistance of the floor of the pelvis.

The broad ligaments are muscles covered with peritoneum, and do not support the weight of the organ but merely oppose flexions of the body on the neck, and resist lateral deviations. In fact, as Barnes Senr says, "The so-called ligaments of the uterus exert but a small influence in preventing prolapsus," and he has frequently seen the uterus in the vagina brought down to the vulva by expulsive efforts at defecation.

As I have above stated, the greatest admirers of the operation admit that it is not at all suitable for displacements with adhesion; and as these are precisely the most troublesome cases to cure by any other means, they are just the ones we are most in need of an operation to come to our aid. But in these we turn in vain to Alexander's operation. The round ligaments would either break before the displacement would be corrected, or else we would have a severe attack of peritonitis or perimetritis.

The only case after Alexanders' operation that I have seen, was not a successful one; as in addition to all the troubles of which she complained before going to hospital, she had a month after-

region was occupied by a firm projection, rightly wards an immense inguinal herina for which she will have to forever wear a truss ; notwithstanding that she was operated upon by one of the best gynecologists in Canada. Besides the operation is not without danger, in fact several deaths have occurred from peritonitis and there may be others from hæmorrhage. So that unless the advantages to be derived are very certain and decided we would hardly be justified in exposing our patients to any risk.

While I do not doubt that Alexanders' operations as above described have been sometimes followed by good results, I am inclined to think that a great deal of the good results may fairly be claimed to be due to the before and after treatment ; for when you have reduced the subinvolution by several weeks treatment, and kept the patient in bed three or four weeks longer after the operation, with a pessary in her, you will have in most cases removed the very necessity of the operation, the uterus no longer being too heavy for its support. But even admitting that it has sometimes or even often been followed by good results, I do not think the cure will be permanent, for the reason that the round muscles are not inextensible fibrous ligaments that will not stretch. If that were the case what would happen in case of pregnancy? The uterus would be unable to rise and abortion would surely follow. Since the shortened round ligaments are capable of supporting the weight of a heavy uterus, and of mechanically prevent it from falling, surely they would be equally able to prevent it from rising from the pelvis under the expansive force with which the impregnated uterus is endowed. But the advocates of Alexanders' operation assure us that we need have no fear of the result of conception, and that the shortened round ligament will offer no obstacle to the upward movement of the organ. And I agree with them. For, as I do not admit the ability of the round ligaments alone to prevent the falling of the organ, a distance of three or four inches, I cannot with any more reason say that it will keep it from rising.

I therefore maintain that Alexanders' operation does not permanently cure retro-displacements and falling of the womb, and that even if it does appear to succeed, there are other safer and more rational means of attaining the same result, and I venture to predict that the operation will not last.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Annual Meeting, October 8th, 1886.

J. C. CAMERON, M. D., 1st VICE-PRESIDENT, IN THE CHAIR.

The annual meeting of the Society was held on Friday, the 8th of October. Drs. J. H. Y. Grant, R. H. Wilson and A. F. Schmidt were proposed for membership.

The treasurer of last year, Dr. Perrigo, and the secretary, Dr. Gurd, handed in their resignations.

The election of officers for the ensuing year resulted as follows :

President—Dr. J. C. Cameron.

1st Vice-President—Dr. Geo. Wilkins.

2nd Vice-President—Dr. Alloway.

Secretary—Dr. R. F. Ruttan.

Treasurer—Dr. A. Laphorn Smith.

Librarian—Dr. Reed (re-elected).

Council—Drs. Geo. Ross, Rodger and Kennedy (re-elected).

Publication Committee—Drs. Kennedy, Geo. Ross and Bell.

Abdominal Sarcoma.—Dr. Geo. Ross, showed organs from a case of abdominal sarcoma. The patient was an active, muscular man, 28 years of age, and came under observation three weeks previously. Six months ago he began to experience lumbar pain, which was called lumbago, and suggestions made of some affection of the kidneys ; suffered much, and at times pain was also felt in the abdomen, not unfrequently accompanied by vomiting ; general health had failed, and he looked somewhat thin and anæmic, although he had kept at his business until the time of his fatal seizure. Having suffered considerably for some days, he was suddenly taken one morning with most agonizing pain in the epigastrium. When seen, he was collapsed-looking, with rapid pulse and cold perspiration. A large quantity of morphia was required before any relief was obtained. The case now looked something like a perforative peritonitis, but the course of events soon negated this. From this time until death, twenty days later, it was absolutely necessary to give frequent hypodermic injections to control the excessive pain. There was great tenderness in the epigastrium, which

believed to be part of the liver. Soon sharp stabbing and very distressing pains were complained of in the lower part of the chest—first on one side, then on the other. There was no physical evidence of pleurisy, but fine and coarse râles were heard over the back and lateral regions of both lungs.

A short cough set in, and, during several days, small quantities of very bright blood were frequently brought up. The diagnosis was, tumor in the back of the abdomen, locality uncertain, but pressing upon the lumbar nerves—the recent and fatal attack being looked upon as due to an acute intra-peritoneal abscess. The specimens were: a mass of sarcoma as large as two fists, which lay against the vertebral column, and had evidently originated in the retro-peritoneal glands. Several nodules of secondary deposit in the liver; the left lobe occupied by an immense clot of blood, entirely disorganizing the part and distending the capsule of the organ (softening of one of the nodules and a profuse hemorrhage into the substance of the liver, distending its capsule had caused the sudden attack described). The lungs contained numerous nodules of similar growth, varying in size from a large pea to a walnut; the largest of them projected considerably from the surface, and corresponded to the seat of the stabbing pains. Dr. Ross remarked upon the importance of abiding pain in any part of the dorsal or lumbar region, with deterioration of the general health, as indicating the presence of such growths in the deep-seated glands. Such hepatic hemorrhage must be a very rare occurrence, and could not have been diagnosed during life.

Stated Meeting, October 22nd, 1886.

J. C. CAMERON, M.D., PRESIDENT, IN THE
CHAIR.

Synovitis of the Knee-joint in Congenital Syphilis.

Dr. LAPHORN SMITH exhibited a boy 12 years old, and read the following notes:—He was brought to me by his mother, complaining of a swelling of the right knee, which he had had for nine months or a year. He also had some ill-looking suppurating sores on his throat and chin, due to glands which had formed abscesses and broken, thus destroying a considerable surface of skin. The knee was very much swollen, only slightly red, not very painful, and not at all hot to the touch. As the swelling was pointing, I opened it,

and a half ounce of thick yellow pus escaped. The peculiar appearance presented by the boy's nose and teeth enabled me at once to diagnose congenital syphilis. His nose is flattened, and his teeth present the peculiar chisel shape which Mr. Hutchinson says is pathognomonic of congenital syphilis. Moreover, the disease of the knee-joint was much less painful than non-syphilitic knee-joint disease generally is. The mother did not know anything about syphilis, but I elicited the following important information: That her first child was born dead; her second was born dead; the third was this one, born at full time, but affected with "snuffles," mucous patches at the anus, and a copper-color rash over the body, for all of which he was treated; the fourth child was born at full time, only had a slight eruption, and is now alive and well. The fifth, sixth and seventh pregnancies were premature. This boy never had interstitial keratitis, nor any other symptoms than those mentioned. She also informed me that her husband was over 40 when he married—a suspicious circumstance, I thought, so I asked her to send him to me. On seeing him, I astonished him very much by telling him that he had had syphilis in his younger days, which he at once admitted. I placed the boy on cod-liver oil, and gray powder alternated with syrup of iodide of iron, generally; and Scott's dressing locally, alternated with tincture of iodine, under which he rapidly improved. I removed him from school, but I did not deem it advisable to confine him to bed, nor even altogether to the house, all of which I would have done if I had considered it a case of ordinary disease of the knee-joint, because I considered it of importance to keep up his general health. The affected knee is now only a quarter of an inch larger around than the other one, which is now perfectly healthy, although it was somewhat full when he first came. Mr. Clutton of St. Thomas Hospital has collected 13 of these cases, which he calls symmetrical disease of the knee-joint due to hereditary syphilis. What is most interesting about these cases is the prognosis, which is very favorable, contrary to that in ordinary cases; and what is remarkable is that there is little or no pain. This boy could hardly be prevented from running as fast as the other boys in the street, although his knee-joint was so full of liquid that the patella distinctly floated. All of Mr. Clutton's cases were in children between 8 and 12 years of age.

DR. BELL considered the case a marked one of

hereditary syphilis, and advised putting the affected joint at rest.

Laryngeal Phthisis.—Dr. Major introduced to the notice of the Society the treatment of Laryngeal Phthisis by the injection of lactic acid into the substance of the larynx.

He briefly referred to the success that had, last winter, attended the use of that acid as a pigment in private and hospital practice. The discovery of lactic acid as a means of local cure was due to Kausa of Berlin, at whose Klinik during the past summer he had ample opportunity of observing the excellent results attending this remedy, when inserted beneath the mucous membrane of the larynx. Dr. Major employed for the purpose Dr. Theodore Herring's (Warsaw) syringe as modified by Kausa. Lactic acid when used by the latter method was particularly prompt in its action, deposits of tuberculous matter underwent rapid absorption, and the local lesion quickly disappeared. It was especially effectual in the early stage of swelling and œdema, cutting the disease short before ulcerative changes had begun. Eight or ten operations, extending over a period of 20 days, would, in the majority of cases, prove sufficient to completely restore a tuberculous larynx.

Dr. Major used a 20 per cent. solution, and injected from 10 to 20 minims at each sitting. The use of lactic acid was not particularly irritating, and did not interfere with the carrying out of other means of a sedative nature. A case under treatment was demonstrated to the members present, in which one side only had at first been acted upon, and the marked difference in the degree of swelling, etc., was very manifest. Other cases undergoing treatment by injection were doing equally well, and would be shown at an early day.

He considered that this plan had already been established as more speedy and permanent than any of its predecessors.

Discussion.—Dr. R. J. B. HOWARD congratulated Dr. Major on the marked effect of this mode of treatment in the case exhibited. In the earlier stages of laryngeal phthisis he usually applied a weak solution of silver nitrate, and later, iodoform and boracic acid. In all cases of ulceration he found this treatment very efficacious. A relapse of the disease was, in his experience, the general rule.

Dr. F. W. CAMPBELL considered the tendency of modern methods of treating phthisis to be direct applications to the seat of the lesion, but did not

believe in neglecting general treatment at the same time.

Dr. GEO. ROSS called attention to the beneficial effect of the treatment in the case exhibited. The interesting point about the mode of treatment is the prospect it opens up of being able to destroy the tubercular focus in cases where pulmonary tuberculosis originates in the larynx. Patients have escaped general tuberculosis by excision of an affected joint. Even in pulmonary tuberculosis, where the laryngeal phthisis is secondary, the relief of the intense pain and distress would be a great boon.

Tumor of the Optic Nerve.—Dr. BULLER exhibited the tumor and gave the following particulars of the case:—This growth was removed on the 16th of April from the orbit of a little girl 7 years of age. The history of the case and the objective signs were sufficiently distinctive to warrant a diagnosis of tumor of the optic nerve before the operation for its removal was undertaken. The child was well developed and in excellent health. About six months previously an undue prominence of the right eye was noticed, and this had slowly increased. Two months previously the vision was tested by a physician and the eye found to be entirely blind, just as it was when I first saw it on the 15th of April. The amount and character of the proptosis can be pretty well estimated by a glance at this photograph taken the same day. The protrusion was considerable, and almost directly forwards; the movements of the eyeball were slightly impaired, but not more so in one direction than another. No signs of any deep-seated inflammatory process existed, nor was there pulsation or bruit, or change in degree of proptosis from placing the head in such a position as would favor congestion of the parts. The ophthalmoscope showed a greatly swollen optic nerve—unilateral choked disc. This, with the complete and early blindness, were strong points in the diagnosis. I hoped to be able to remove the growth and return the eyeball in position. After dividing the attachment of the outward rectus, and passing the finger between this muscle and the eyeball, it was easy to feel the enormously swollen nerve and trace it to the optic foramen, where it was removed with curved scissors and afterwards separated from the eyeball. There was only moderate bleeding, and, as far as the manipulative procedure was concerned, it would have been easy to return the eyeball; but,

on finding that the pulpy growth over the sheath of the nerve extended right up to the optic foramen, I thought the chances of preventing a recurrence of the tumor would be improved by a free application of chloride of zinc paste to the apex of orbit, and under these circumstances deemed it useless to attempt to save the eyeball. Accordingly the eye was removed and the zinc paste applied. The child made a good recovery, and returned home in two weeks after the operation. The growth, you will see, is all contained within the sheath of the optic nerve, and forms an ovoid mass about 25 mm. in length and 15 mm. in diameter; it was tolerably firm, and had a pulpy, semi-transparent appearance when removed. I suspect it is a myxo-sarcoma, but Dr. Johnston has kindly made an examination of its histological structure under the microscope, and will perhaps kindly favor us with the result of his investigation.

DR. WYATT JOHNSTON reported the result of the microscopic examination. No trace of nerve tissue was found. The growth was fibrous, and was characterized by a fine meshwork resembling a glioma.

In reply to DR. BELL, DR. BULLER stated that there was no recurrence of the growth.

Progress of Science.

TREATMENT FOR THE VOMITING OF PREGNANCY.

BY GEO. J. ENGELMANN, M.D., ST. LOUIS, MO.

The question, "How do you treat vomiting of pregnancy?" is one often asked, and one which almost as often receives a varying answer. The question is full of interest and importance, and although frequently occurring to the practitioner, it has not received proper attention. For various reasons the trouble is an annoying one, and it is as frequent as it is annoying. The remedies recommended or the treatments advocated differ widely, yet, odd as it may seem, there is good reason for this. Physicians who have obtained good results with some remedy or method of treatment naturally favor that and thoughtlessly recommend it for vomiting of pregnancy in general. It is tried, and and it fails. Others succeed with methods differing widely, hence we come to no understanding, nor do we arrive at any satisfactory conclusion as to the method of treatment. To do this we must consider the *nature and cause of the disorder*.

The vomiting of pregnancy is *not a disease*, but a *symptom*, and a symptom varying greatly in character as determined by the underlying cause. From the moment that we cease to look upon this disturbance as a *disease* to which a certain line of

treatment is applicable, and view it *merely as a symptom arising sometimes from one disorder and sometimes from another*, the plan of treatment to be adopted will be reached more readily and with greater certainty.

We must distinguish between the vomiting of early pregnancy and the vomiting in the later months of pregnancy; the vomiting of the early months of pregnancy is always a neurosis, due, either to the distention of the uterus, or to reflex nervous influences dependent upon the recently established gestation—that is upon physiological causes and physiological conditions, or in other cases upon pathological conditions, such as narrowing of the cervical canal; erosion of the cervix by friction upon some part of displayed organ. In the later months of pregnancy the vomiting is not always a neurosis, a gastric hystero-neurosis; but may be due to a local irritation, to pressure upon the stomach by the enlarged uterus or to some disturbance in the gastro-intestinal canal or its nerves, brought about by the very much enlarged uterus.

TREATMENT OF VOMITING IN THE EARLY MONTHS.

In those cases in which the vomiting is merely a reflex neurosis due to physiological changes in the uterus, we must attempt to quiet the irritated gastric nerves and give tone to the system. I then advise the use of some of the mild remedies so frequently recommended; there are many effective and well known, but I will merely mention those which I use and upon which I have learned to rely, never having cause to seek for others. I generally give a powder composed of lactopeptine 60 gr., bicarbonate of soda, 60 gr., sugar with oil of peppermint, 60 gr., a little rhubarb 10 to 20 gr., with gentian or ginger 5 to 10 gr., giving a knife-point full before and after meals. When the stomach feels faint I give a teaspoonful of a mixture of bitter almond water 1 oz., with orange flower water 1 oz., and a little hyosciamus 2 to 6 gr. In case this treatment is not followed by speedy improvement I give a teaspoonful of a one per cent. solution of carbolic acid in water, but never fail to quiet the stomach with ten drops of a four per cent. solution of cocaine (cocaine hydrochloral 2½ gr.: aq. dist. 60 drops).

In many instances, however, we will find some slight local disturbance, some displacement of the uterus, and eroded cervix, an endocervicitis, and in these cases the local condition must be looked to. In rare cases only have I used the strong remedies. I generally succeed with mild applications a ten per cent. solution of carbolic acid to an inflamed cervical canal, or with the dry treatment of an erosion, dusting the surface with bismuth or iodoform and retaining the uterus in place and dressing the part with a tampon of tannated or borated cotton. I have never been obliged to resort to dilatation of the canal, which was quite the fashion at one time. It was spoken of a great deal highly recommended, but now seems to have been forgotten, and justly, because it is dangerous and rarely necessary. Where we succeed with dilata-

tion of the canal we will succeed as well, if not better, by a mild astringent application, the narrowing of the canal being often due to a swelling of the tissues, whether physiological or pathological and by reducing this we widen the canal more safely than we do by distention. Possibly there are some cases in which it is called for, but milder means and safer ones, will generally answer—I may say always, if the disorder is not allowed to progress and treatment is at once inaugurated. Applications of a four per cent. solution of cocaine, or pure salt to the canal and to the eroded cervix, I have found useful as a means of affording immediate relief. It is desirable to stop the vomiting for the time being and immediately. As a rule I have followed the use of cocaine by the application of a mild astringent or the ten per cent. carbolic acid solution. Cocaine quiets the nervous irritability and prevents an injurious action of the drug itself, whilst the astringent affords permanent relief. But whatever treatment is adopted, the physician must not fail to see that the bowels are well regulated and that proper diet is observed. In mild cases when medication is not desired or feasible, I am very fond of following an old German custom. I advise the patient to take a small cup of strong coffee upon awakening in the morning—best without sugar or cream—then to remain quietly in bed for an hour before getting up.

TREATMENT OF VOMITING IN THE LAST MONTHS OF PREGNANCY.

In the last months of pregnancy the nausea and vomiting are not so persistent as in the early months and less often due to pathological conditions of the uterus. It is caused by pressure of the enlarged organ either upon the stomach or some of the sympathetic centers or as in the early months, it is a hysteroneurosis—is due to the physiological condition of the uterus or to pathological changes will afford relief. I have invariably succeeded with the use of mild astringent applications about the cervix. When the latter is the case, local treatment is called for as in the earlier months; I would emphasize this, as the local treatment in the vomiting of the last months of pregnancy is altogether too much neglected. I have succeeded in checking most persistent, almost fatal, vomiting in the last months of pregnancy, after all possible methods of treatment had been tried by homœopathy and allopathy, by local applications to the cervix.

Vomiting at this time, if from local causes, is generally due to tension upon the nerves by the swelling of the cervical tissue; astringent and anodyne applications will afford relief. I have invariably succeeded with the use of mild astringent applications, and the continuous use of such remedies applied by means of the tampon, either in powder or in solution with glycerine.

Tannin, carbolic acid and iron may be used alone or in a variety of combinations applied with the glycerine tampon. The mild application of a

galvanic current to the cervix sometimes affords speedy relief if other means fail. A strong current, however, must not be used; and in case of great gastric irritation the positive pole of the galvanic current upon the stomach, the negative pole upon the spinal cord, will allay this aggravating gastric irritation. A faradic current may also be tried.

I have never been obliged to resort to electricity, by reason of the failure of other methods, but have tested it successfully in cases which I did not resort to my usual treatment.

The question may be asked, how are we to tell what treatment to use; how are we to know the nausea and vomiting? I make it a rule to examine the patient and inquire into her general condition, and if a local examination reveals any marked pathological change this should be at once remedied. If nausea and vomiting do not then cease, internal medication may be resorted to, but as a rule it will be found that upon proper treatment of the local disturbance nausea will cease. On the other hand, if there be no such disturbance, we at once resort to internal medication; and if this is not successful and speedily so, we must act upon the supposition that the vomiting is due to the physiological condition, and then we may resort to the use of cocaine, either internally or applied to the cervix and cervical canal, or we apply anodyne and astringents to cervix by tampons and if necessary to the cervical canal itself.

I have never seen a case that did not yield to treatment, local or general, if not applied at too late a stage when the patient was almost in collapse.

And yet you will say that fatal cases not unfrequently occur. This is true, but it is not because we have no certain means of overcoming the disorder, it is because relief is sought too late. For such fatal results medical teachers and medical text-books are to the great extent accountable. There is a wide-spread belief among the laity, deeply rooted among mid-wives and knowing old women, that the vomiting of pregnancy is a natural condition and should not be interfered with; and I am ashamed to say that text-books cultivate this belief, teach it to the physician; and among the older members of the profession, graduates of early days, it is almost a universal rule not to disturb the vomiting of pregnancy, unless it becomes persistent and severe. Excellent physicians pay no attention to the complaints of pregnant women when suffering from nausea and vomiting, and even the most modern of text-books say that we should not or need not interfere with nausea and vomiting, unless it becomes so severe as to endanger life. Even Lusk, that excellent authority, tells us so and quotes from an equally prominent German author, the recipe of an obstetric authority who when the young wife told him of her trouble, laughingly advised her to "go upon a visit to her mother," meaning, in other words, that treatment is needless or powerless and the best you can do is to have a good time and a change. These are not teachings as we should expect them in the present era

of medical progress. The student should be taught that this is a morbid symptom due to some pathological condition as it is most undoubtedly; which should be overcome at once! the sooner the attempt is made the more likely it is to prove successful. Why must the patient first be weakened by lack of food and long suffering, and even in danger of life before we interfere? If it is right to interfere then, it is right to interfere when the trouble is first inaugurated, and it is then most easily overcome. Mild remedies, careful diet and proper regime will easily check the nausea and vomiting when it first appears, and naturally so, as the patient is in a much better condition to respond to treatment than when weakened by months of suffering. Should, perchance, all treatment fail the uterus must be at once emptied, and we should, under no circumstances fail to bring about a miscarriage. If not delayed too, long relief is instantaneous. But unfortunately this operation is looked upon as a desperate *dernier resort* put off from day to day, until the sufferer has lost her vitality and succumbs, when at last it is determined upon. If performed in time the operation is accompanied by very little risk and is sure to afford relief.

If I have succeeded in impressing upon your readers that it is the duty of the physician to treat this disorder, and to treat it when it first appears; if I have succeeded in showing the failure of the old teaching, and the old women's belief that we must not interfere, unless it becomes dangerous, then I have rendered you a far greater service than by recording any one method of treatment.

NASAL CATARRH.

BY G. Q. ORVIS, M.D.
SEYMOUR, INDIANA.

[Read to the Mitchell District Medical Society, at Seymour, June 4, 1886.]

I present to you to-day a short paper on Nasal Catarrh, or a more appropriate term Rhinitis.

This term applies to the abnormal condition we so often find affecting the membrane which lines the nasal cavities, and may be in the acute, sub-acute, or chronic stage. As to form we may find either the simple, the hypertrophied, or atrophic.

The latter being known as *œzema*, and should be treated as a separate disease. Rhinitis in the acute stage is generally known as *coryza*, and mucous membranes continuous with the Schneiderian, lining other cavities, is generally affected at the same time. The condition we know as a bad cold, hay-fever, and the *coryza* present during exanthematous fevers are forms of acute rhinitis.

It is from the frequent recurrence of this acute trouble that the subacute and chronic forms appear; it is this condition that is most often seen by the physician, and it is the disease in this stage with which this paper will deal.

To correctly understand rhinitis we must look at the anatomical structure with which we come in

contact, and we find a membrane lining the nasal cavities extending to other cavities, composed of a basement membrane of areolar tissue that contains numerous mucous secreting glands, covered externally by epithelium of the ciliated variety, through which the ducts of the mucous glands open and pour forth their excretions. This membrane is abundantly supplied with blood vessels, both arterial and venous, and its nerve supply is very liberal, coming from the four systems of nerves, viz.: the special sense, the sympathetic, the motor, and the common sensor. That part of the membrane above the middle turbinated bones is known as the olfactory membrane, and receives the olfactory nerve filaments; therefore is the membrane of smell.

The cilia on this membrane are longer, and the venous supply is less; therefore, we have a darker colored surface here than in other parts of the nasal cavity. The membrane below the middle turbinated bones is known as the pituitary membrane. Nothing in particular is necessary to say about this, except the support which it gives to the blood vessels is very poor; congestion takes place easy and soon becomes passive. These membranes or membrane, as we choose to consider it, covers the bony and cartilaginous walls of the nasal cavities; also covers the turbinated bones found in the cavities. The structure of these bones is peculiar, they being almost semi-cartilaginous of many surfaces and very liberally supplied with vessels; they are thinly covered with tissue, and when their covering is irritated becomes greatly enlarged by the engorgement of blood, especially when the irritation is lasting or often repeated. This imperfect anatomical sketch will be sufficient for our use in this paper, and we will look at the physiology for a moment.

The most important function is for the preparation of the air, which passes over its surface during respiration. The inspired air is warmed, and probably a certain amount of moisture added to it in passing over the Schneiderian membrane. This fact is proven in two ways: first, if we have complete stenosis of nasal cavities, and the person so affected becomes a mouth-breather, we are sure to have acute inflammation of the lower part of the respiratory tract; indeed, so true is this, that I am quite sure it could be proven that all persons suffering from asthma are mouth-breathers. Two cases which I have treated for asthma quite recently, and which are well-known to all of the physicians in the city, are both suffering from nasal stenosis, and both inspire air through their mouth.

The cause of this inflammation is no doubt an improper condition of the inspired air when it reaches the bronchi and air cells, being too cold and dry, and not as nature had intended it to be.

Another proof is, that the great danger in tracheotomy is the congestion and extension downward of the inflammation, and consequent closure of the air cells produced by cold inspired air; in fact, so great is this danger that intubation of the larynx is now coming into use, and is more successfully used.

than tracheotomy, and no other reason can be given for its superiority. The special function of smell we will not dwell upon, as it is generally known that its loss causes no great inconvenience, and, therefore, to the human race is not very important, although in the brute creation it is one of the most important of senses. Another function is the act of excretion, and just how far this affects the human system we are not prepared to say, but no doubt there is a great deal of morbid material taken out of the circulation in this way, and when it is checked a great many ailments may be caused, which are well understood when we work out the problem of re-absorption of worn out matter and reflex irritation.

We will now notice the pathological conditions we find in rhinitis, and then pass on to the treatments supplemented by the clinical history of a few cases that have been in our care. We always find in chronic rhinitis a discolored membrane, and if the disease has not passed from the hypertrophied condition, is considered the true state of this trouble, we have a thickened membrane with enlargement of a part or all of the turbinated bones and thickening of the vomer. The symptoms of this condition are lassitude, fever, and stenosis, or, as the patient describes it, a stuffy feeling in the head. Auxiliary symptoms are local pain caused by pressure upon some nerve filament, reflex headache, deafness, caused by stoppage of the nasal orifice of eustachian tube, pharyngitis from extension, and ocular conjunctivitis.

The treatment for catarrh is as varied as the number of patients you meet; no set treatment will answer your purpose. First of all to remove the cause and to illustrate this I will cite a case.

My first case of rhinitis was in the six-year-old son of a Mr. S. of this city. The left nostril was closed by the thickening over the external end of inferior turbinated bone and the swelling above this caused a bulging of the left alae of the nose that was very perceptible. A very fetid discharge was oozing from the nostril, and the boy was suffering from what appeared to be remittent fever.

In this case fortune favored me; for without scarcely knowing why I should do it, I introduced a blunt probe, and my maneuvers dislodged a good-sized piece of a chip, which was blown out of the nostril by an effort of the little patient to get away from the cruel probing he was undergoing. I then supplied the mother with a Pierce nasal douche, and gave her directions for using it, and requested her to bring the boy to me again in three days.

She did so and I found the nostril quite open, the swollen condition reduced very much, and another piece of a chip in sight, which I removed; and in a few weeks the nose was entirely well. I learned that this boy had been treated by two of our older physicians, for several months, and one of them had pronounced it cancerous. In a blundering way I had relieved the boy and made myself famous in the eyes of this family. From this one case I learned to always try and remove the cause if it can be found. If scarlatina, or any

of the other exanthematous fevers be the cause, then treat them, and oftentimes when the constitutional troubles they produce are gone our catarrhal trouble will cease.

Undoubtedly catarrh is more prevalent now than in years past, and is perhaps caused by inhaling poisonous gases and bad air. It is not always easy to remove the cause, and must be treated by remedies suitable for its cure. When we find ulceration and sloughing going on we may expect to find pressure from some source over the ulcerated surface, and generally this is made by hypertrophied tissue opposite the excoriated surface.

If the condition has been long present, as we will learn by subjective examination, and we feel positive that medical applications are of no avail, then the best means to employ is something which will remove the redundant tissue. If this be soft the Jarvis snare is most convenient, and is used by first transfixing the lump, and then drawing the wire around it when the part comes away readily.

To illustrate, I will report the case of Mrs. S., a young German woman, who came to me three years ago suffering with bronchitis, as she thought, and so it was, but this was not the primary trouble; she had a very bad pharyngitis and rhinitis, the latter, in my opinion, being the cause of all the other conditions. I treated her by swabbing, and brushing, and internal medication, for nearly a year, until I left my practice and went away to brush up, with but slight success. Upon my return the patient returned and, having given this disease some attention while away, I made a more thorough examination, and found a badly hypertrophied condition of the posterior ends of the inferior turbinated bones; these lumps I cut away, by using a transfixing needle and a pair of long scissors, a rather rude way but still it was successful, and in a few months I was rewarded with a perfect cure; the pharynx returning to its normal condition under the use of astringents; the bronchitis has left and the lady now reports herself well.

The medication used was liq. hydrastia, mur. amon. in solution and tr. ferri. mur. applied in spray-form. Sometimes cases present themselves to you where there is simply congestion, but not enough to amount to hypertrophy; in this class of cases we must rely on applications, and one giving me the best result is argenti nitras in spray-form used every third day, followed by placing a little bit of an ointment made by mixing glycerine and boracic acid, evaporating to a semi-solid consistency by heat, and in a short time our efforts are crowned with success.

Another condition we often meet with is where there is an osseous enlargement that is pressing some opposing part and causing irritation; this must be removed, and the most efficient means for this removal is the multiple knife, which is made to revolve by the motion of the hand, or a foot-lathe, and cutting away the growth, and bringing the part drawn to a level. Another instrument used is the pointed scissors and forceps.

Not long since a young man presented himself

to me for treatment for catarrh. Upon examination I found a sharp node grown out from the vomers and the tissue opposite considerably excoriated.

In the act of respiration you could see the part, rub against each other, and it was easy to account for his catarrh.

After a few weeks of treatment to heal the excoriated surface, and to relieve the inflammation as much possible, I removed the node with the jointed scissors, and the case is progressing rapidly towards recovery. Another remedy often used is caustics, either solid or acids, to produce a slough, but if the osseous tissue is enlarged this will fail, and if only the soft tissue be involved surgical aid is much nicer and more pleasant for the patient.

There are other remedies, such as the galvano cautery and pastes to be applied, but these should only be used by the most expert manipulators, and I have tried to keep within the pale of the regular practitioner, only giving those remedies which can be used by any careful, observing physician.

I have only spoken of true nasal catarrh, not having touched *ezena*, which is catarrh in an atrophic form, thinking that this had better be left to itself, as it is a condition hardly ever cured—only relieved.

In closing I wish to speak of the application of remedies and the best mode of procedure.

First of all the membrane should be thoroughly cleansed of all mucous, and this is best done with a cotton swab and some alkaline solution, and then thoroughly sprayed to be sure that all folds are clean, then throw your medicated fluid in the form of spray forced by condensed air or hydraulic pressure, and use enough pressure to be sure that every fold and sinus receives some medication; there need be no fear of injuring the middle ear by this method, or in doing any other damage, and you leave no corner for the disease to hide in, and again light up the whole surface of the nasal cavity.
—*Progress.*

THE DIETETICS OF PULMONARY PHTHISIS.

BY ALFRED L. LOOMIS, M.D., ETC.

The dietetics of pulmonary phthisis is often the most difficult as well as the most important element in its successful management.

In the limited space at my disposal I can give only general rules, and an outline of the practice which experience has led me to adopt.

Three things require consideration:

- 1st.—*The most suitable articles of food.*
- 2nd.—*The time and quantity of its administration.*
- 3rd.—*The use of artificial digestives.*

Since the object sought is the maintenance of the highest possible nutrition, and as this must often be done with feeble digestive and assimilative powers, the selection of food will not be determined solely by their relative value (chemically) as food products, but quite as much by the facility with which they are assimilated.

The best foods are those from which the system gains the most heat and force producing elements, with the least proportionate expenditure of digestive and assimilative force.

Milk is undoubtedly the best food of all *per se*, but in many cases with weak digestive power more nutrition is gained from its weaker ally Kumyss.

Of the albuminoids, meats, especially beef, and eggs are the most valuable.

The best hydrocarbons are cod liver oil, butter, cream, and the animal fats. Sugars and starches should be avoided as far as possible, since they tend to fermentation, and cause both gastric and intestinal dyspepsia. Only occasionally will a patient be found who is benefited by their use. They should be employed, therefore, only for variety in diet, and to avoid that disgust for all food so apt to be engendered by a monotonous diet.

Phosphorous, so important especially in tubercular cases, is secured in preparations of the phosphates, which should not be in the form of syrups. Vegetables and fruits may be required in the earlier stages to avoid monotony, and later to satisfy a capricious appetite, but they should be restricted to the minimum and to such as contain the least saccharine elements.

Two very distinct classes of phthisical patients must be recognized, those under thirty and those over forty. It may be stated as a general rule that for the first class the basis of all dietetic treatment must be the hydrocarbons and phosphates. They are often the *curative* agents in young subjects.

On the other hand the albuminoids must constitute the principal food of the second class. It is worthy of note that often in phthisis the demands of waste and repair not only enable young people, who usually object to all forms of fat, to take and assimilate, but even cause them to exhibit a decided fondness for all forms of fatty food. Older subjects, who in health use little albuminous food and more fat, are able to digest large amounts of meat, while fats cause intestinal dyspepsia.

In selecting special articles of diet for these two classes, it is important to remember that there are distinct stages which consumptive patients pass through, as regards digestive powers. The first covers the period during which digestion and appetite are unaffected. The second begins with the first indications of septic infection; is marked by intermittent pyrexia and gastric intractability. It extends to the time at which the stomach refuses solid food. The third covers the remainder of the patient's life. It is in the first stage that the best results are obtained.

Systematic dieting should be begun, therefore, upon the first suspicion of a developing phthisis. The diet can no longer be indiscriminate, but the rules given below should be strictly adhered to. For young patients meat must be, and butter and cream are to be used freely. Milk should consti-

tute the principal drink, in quantities of from two to four quarts per day. Other articles are to be taken sparingly, simply to avoid monotony. Each meal is to be supplemented by a generous allowance of cod liver oil ($\frac{3}{4}$ ss $\frac{3}{4}$ ii). The phosphates so valuable to this class of patients can be supplied in sufficient quantity only by special preparations. For patients over forty, meats should be lean rather than fat, and be taken in large amount. Two to three pounds of beef, three to four quarts of milk, and three or four eggs may be given to such patients in twenty-four hours.

In the second stages, changes are required in the methods of preparing the food rather than of the articles employed. All the food must be given in fine division and prepared in the most palatable manner. Beef may be scraped or chopped with a dull knife, only the fine which adheres to the blade being used, and eaten raw, or lightly or quickly cooked, the essential points being the removal of all coarse fibre, and rendering it palatable to the patient. Milk may be taken raw, boiled, cooked in custard, curdled or shaken with cracked ice and a little salt. Eggs are best taken raw or soft boiled. Kumyss may in part take the place of milk, and the various peptonoids of beef, milk, etc., will relieve the enfeebled digestive organs as well as afford valuable nutrition. Cod liver oil will require emulsification, and fresh emulsions are to be preferred to the stock preparations. Practically I have found an emulsion of oil, pepsin and quinine available, when others caused indigestion and offensive eructations.

In the third stage when only prolongation of life can be expected, the forced diet of the earlier stages must be abandoned. When a hearty meal causes cough and vomiting with consequent exhaustion better results will be obtained with smaller quantities of food. In such cases the food must be reduced in quantity, given more frequently, and should consist largely of artificially digested preparations.

It is quite customary to delay the use of the digestive ferments until the later stages of the disease, but since it is in the first stage almost solely that we effect a cure, it seems the wiser course to concentrate all our forces upon the disease at this time.

When we wish to crowd the nutrition, twenty to thirty grains of pepsin, with fifteen to twenty minims of Acid Hcl. directly after eating, and ten to fifteen grains of pancreatine one hour after taking food, will enable a patient to digest an amount of food, which otherwise would produce an acute dyspepsia. When the digestion of starches is at fault or requires assistance, the diastase alone may be given with or after the meal. In the second and third stages artificial digestion becomes a necessity.

Some of the most important rules which govern the dietetics of phthisis may be formulated as follows:

1. Every phthisical patient should take food not less than six times in twenty-four hours. The three full meals may be at intervals of six hours, with light lunches between.

2. No more food should be taken at any one time than can be digested easily and fully in the time allowed.

3. Food should never be taken when the patient is suffering from bodily fatigue, mental worry, or nervous excitement. For this reason mid-day naps should be taken before, not after, eating. Twenty to thirty minutes' rest in the recumbent posture, even if sleep is not obtained, will often prove of more value as an adjuvant to digestion than pharmaceutical preparations.

4. So far as possible each meal should consist of such articles as require about the same time for digestion, or, better still, of a single article.

5. Within reasonable limits the articles of any one meal should be such as are digested in either the stomach or intestine alone, *i. e.*, the fats, starches and sugars should not be mixed with the albuminoids, and the meals should alternate in this respect.

6. In the earlier stages the amount of fluid taken with the meals should be small, and later the use of some solid food is to be continued as long as possible.

7. When the pressure of food in the stomach excites cough, or when paroxysms of coughing have induced vomiting, the ingestion of food must be delayed until the cough ceases, or an appropriate sedative may be employed. In those extreme cases where every attempt at eating excited nausea, vomiting and spasmodic cough, excellent results are attained by artificial feeding through the soft rubber stomach tube.

8. So long as the strength will permit assimilation, and excretion be stimulated by systematic exercise, and when this is no longer possible the nutritive processes may be materially assisted by passive exercise at regular intervals.

The following may serve as a sample menu for a day in the earlier stage. The meat soup is made by digesting finely chopped beef (1 lb) in water (Oj) and hydrochloric acid (5m), and straining through cheese cloth.

MENU.

On waking.—One-half pint equal parts hot milk and vichy, taken at intervals through half an hour.

8 a.m.—Oat meal with abundance of cream, little sugar; rare steak or loin chops with fat, cream potatoes; soft boiled eggs, cream toast; small cup of coffee, two glasses of milk.

9 a.m.—Half ounce cod liver oil, or one ounce peptonised cod liver oil, and milk.

10 a.m.—Half pint raw meat soup; thin slice stale bread.

11-12.—Sleep.

- 12.30 p.m.—Some white fish ; very little rice ; broiled or stewed chicken ; cauliflower ; stale bread and plenty of butter ; baked apples and cream ; milk, Kumyss or Matzoon, two glasses.
- 2 p.m.—Half ounce cod liver oil, or one ounce peptonised cod liver oil and milk.
- 4 p.m.—Bottle Kumyss or Matzoon ; raw scraped beef sandwich.
- 5.30-6 p.m.—Rest or sleep.
- 6 p.m.—Some thick meat or fish soup ; rare roast beef or mutton ; spinach ; slice stale bread ; custard pudding ; ice cream.
- 8 p.m.—Half ounce cod liver oil, or one ounce peptonised cod liver oil and milk.
- 9-10 p.m.—Pint iced milk ; cup meat soup.
- 1-2 a.m.—Glass milk, if awake.

CHRONIC PROSTATITIS.

(By W. H. DANFORTH, M.D., Boston, Mass., asst. at the Disp. Clin., for Genits Urinary diseases.)

Northwestern Lancet :—Chronic prostatitis is, in the majority of cases, the result of a gonorrhœa, where the inflammation has passed the compressor urethræ or the prostate itself.

Next in frequency as causes come masturbation and excesses in venery, as these habits keep up a continual congestion in the prostatic region ; but in this case the inflammation is chronic from the beginning, and usually the secretion is mucous and not purulent.

The disease may arise from stricture, unskilful instrumentation, irritating drugs, and, perhaps, from the passage of concretions and sand in the urine.

Probably the prostate itself is not always affected by the inflammation ; for it is often found normal in size and not tender to the touch ; this is most noticeably the case in the chronic cases arising from masturbation. For this reason it seems incorrect to apply the term "prostatitis" to every inflammation in the prostatic urethra. The inflammation probably always begins in the mucous membrane of the urethra, and may or may not extend into the follicles of the gland later.

If we adopt Ultzmann's view, we apply the term "catarrh of the neck of the bladder" to all inflammations of the posterior part of the urethra, whether involving the prostate or not.

When an acute attack of prostatitis comes on during a gonorrhœa, it is announced by very frequent and painful micturition, weight and throbbing in the perineum, pain on defecation, and, perhaps, an attack on retention. The symptoms of the chronic form, whether from an acute case or other cause, are as follows : (These will not all be seen in the same patient, usually.)

(1) Increased frequency of micturition, but much less than in the acute form. Ultzmann's says : "Frequent micturition in the disease of the posterior urethra is such a very characteristic symptom, that from the presence of this sign alone we can always conclude with certainty upon a lesion in the neck of the bladder." (2) "Bearing down"

and uneasiness in the perineum and anus. (3) Slight pain or uneasiness at the end of micturition. (4) Tenderness around the prostate on passage of a sound. In long-standing cases the urethra becomes anæsthetic, and this symptom is lost. (5) Inability to urinate on making the attempt is a prominent symptom. (6) Diminution in the force of the stream and dribbling after micturition. (7) Reflex spasm of the compressor urethra ; this is of common occurrence. (8) Frequent erections and erotic desires, as well as frequent seminal emissions at night, are often complained of ; but in cases of long durations the opposite extreme is found, and partial or complete impotence may be present, causing the utmost depression. (9) There may be a discharge of mucus from the urethra, showing the presence of inflammation anterior to the compressor urethra ; when, however, the inflammation is confined to the prostatic urethra, the secretion appears only in the urine. This, of course, is due to the strength of the compressor, keeping back secretions posterior to it. (10) Mucus may be discharged from the urethra during straining at stool, simulating the discharge in spermatorrhœa ; the microscope settles this point. (11) When the urine is passed in two portions, characteristic appearances are seen. Ultzmann says, "If only a little secretion has collected in the posterior urethra the urine in the bladder remains uninfluenced, and if we have the patient urinate successfully in two glasses, only the first portion of the urine passed will appear turbid, the second half remaining clear and transparent. If, however, the secretion in the posterior urethra is considerable in amount, it will flow back into the bladder, make the urine more or less turbid and even irritate the bladder itself.

In this case, both specimens of urine (passed into two glasses) will appear turbid. However, as a distinction from a primary cystitis, the first half of the urine will appear more turbid than the second and will contain more compact flakes, which all come from the urethra, and which accordingly are absent from the second portion of urine passed." (12) These "flakes" are the so-called "prostatic shreds," and consist of short, thick, clumpy masses, which, under the microscope, are seen to be collections of pus, prostatic epithelium and mucus, with sometimes a few spermatozoa. They occupy the follicles of the prostate, and are washed out by the urine. (13) Shreds from the anterior urethra may also sometimes be seen in the first portion of the urine ; these are longer and thinner, and consist of pus and urethral epithelium. (14) The urine contains mucus, prostatic epithelium, pus, often spermatozoa, and sometimes blood corpuscles.

A trace of albumin is often seen, which disappears when a cure is effected. (15) On rectal examination, the prostate is usually found somewhat enlarged and tender ; it may be normal in size and not tender. In which case the inflammation is probably mostly in the mucous membrane of the urethra. (With enlargement of the gland there may be residual urine.) (16) Neuralgic pains in

the back and groin are frequent subjective symptoms. Dr. F. S. Watson says: "These pains vary as to constancy and duration, and may be entirely absent."

The frequency of micturition, with pain, and blood appearing at the end of the act, may simulate the symptoms of stone in the bladder. This happens only in the acute cases, and rectal examination and sounding make the diagnosis clear. True hypertrophy of the prostate occurs only after the fiftieth year, and can hardly be mistaken for an inflammation.

In cystitis the pain is felt above the symphysis pubis instead of in the perineum; the urine is generally alkaline and the second part of the urine is as turbid as the first. Cystitis is, however, often associated with a chronic catarrh of the neck of the bladder.

The treatment should be both general and local.

The patient should take no alcohol, he should sleep on a hard mattress in a cool room; he should take moderate exercise daily out of doors; his bowels should be kept open, and he should be given tonics and plenty of nourishing food. The urine must be kept dilute and unirritating by diuretics.

For this purpose benzoate of soda, twenty grains, given four times a day, is an excellent remedy.

Locally, counter-irritation to the perineum is beneficial. One side of the raphe is to be painted with cantharidal collodion or tincture of iodine, and in a few days the other side. This may be kept up for some time, and will usually relieve the sense of weight and uneasiness. (Care must be taken to prevent the irritant from touching the anus.)

Together with this the prostatic injection of nitrate of silver is probably the best remedy. It is best to begin with a solution of two grains to the ounce, and increase to five grains. In making the injection it is well to pass a good-sized sound first, in order to stretch the urethra so that the fluid may readily penetrate to all parts. (The sound should be lubricated with glycerine, as oil will form a coating over the urethra and modify the effect of the application.) Then a drachm of the warmed solution is to be injected slowly, the point of the syringe having been located at the prostatic urethra by the finger in the rectum.

Ultzmann's syringe catheter, fenestrated on the sides, connected by a rubber tube to a small syringe, is the most convenient instrument to use.

The application should be made twice a week, using no more than a five-grain solution, and the treatment kept up for six or eight weeks. If, in that time, no improvement is noticed, the injections should be discontinued for a time and other means employed.

Combined with the deep injections and counter-irritation, large sounds should be passed once or twice a week. In the large majority of chronic cases the above treatment will bring about good results. It is particularly applicable to the chronic "masturbation cases."

THE USEFUL ADMINISTRATION OF ARSENIC IN DISEASES OF THE SKIN.

By EDWARD L. KEYES, M. D.

The short article which appeared in the first number of the *New York Medical Monthly*, from the able pen of Dr. Fox, upon "the useless administration of arsenic in diseases of the skin," seems to me to call for a word of protest from some one who thinks better of this drug than Dr. Fox appears to do, and especially so since the editor of the *Journal of Cutaneous and Venereal Diseases*, in *Medical Record* of June 26, has made a general call for expression of opinion upon this important subject.

The words of Dr. Fox and his argument, as he puts it, can hardly be controverted, but the implications of his article, and the generalizations which are sure to be drawn from it, seem to me to be damaging in their tendency, and likely to be effective of more harm than good; and, therefore, since it is a very poor question which has not two sides, I wish to say a word on the other, and what seems to me to be the better side.

The general practitioner who has his routine prescription for all known symptoms, and who, upon seeing a malady of the skin, takes his pen and orders five-minim doses of Fowler's solution three times a day, in the vague conviction that by so doing he has performed his whole duty to his patient, is undoubtedly condemned by this simple act, and all that need be said of him or to him is that he ought not to treat skin diseases at all.

The value of diet, of hygienic measures, of topical applications; the study of diathesis, and the just appreciation of the cause of a given skin disease—all of these are doubtless more valuable factors of treatment than the administration of any drug, and a physician is hardly worthy of the name if he relies upon medicines alone in the management of any malady—cutaneous or general. In so far, therefore, it appears to me that the generalizations of Dr. Fox are accurate; but beyond this they appear faulty, because they seem by implication to attempt to weaken general confidence in a remedy which, carefully used, holds a very high if not the first place in cutaneous general therapeutics, notably in the management of chronic disease.

The same rebuke (*i. e.*, routine administration) may, with equal justice, be cast at cod-liver oil and the hypophosphites as to their applicability to phthisical maladies, at colchicum, at quinine, at mercury, at iodide of potassium, or at any other drug. One man may use any of these remedies without effect against a malady over which they are well known to exercise a more or less controlling influence, and he may fail; while another practitioner, continuing the same remedy and intelligently supplementing it by other means, may conduct his patient safely to a cure.

I am not in a position to champion arsenic or any other remedy as a general "skin disease," but

if there is any other drug more far-reaching in its influence for good upon the skin in a general way I have yet to learn it, and Dr. Fox has not suggested what it is.

My observation and experience in relation to the use of arsenic allow me to generalize only upon a few points.

Arsenic is distinctly a cutaneous stimulant; therefore, in the initial stage of a malady possessing an inflammatory element (notably eczema), it is not only not useful, but may be actually pernicious. Used after the acute stage has been controlled by appropriate means, it often speeds the parting crust and prevents it from lingering in a state of prolonged and desperate chronicity. A fitting analogy is the use of friction and passage in joint disease. This remedy is very efficient, but it has its time and place. When the joint is acutely inflamed, massage only adds fuel to the flame; but when the fire has been subdued, then the stiffness and loss of motion, perhaps otherwise inevitable, may be often overcome by the skilled application of massage. If the joint would get well without the massage, there is no call for its use, and no one but a routinist would employ it, yet that it has its use can hardly be denied, and so with arsenic.

Arsenic, in my opinion, is not useful unless the stomach tolerates it well and appropriates it in a kindly way. When digestion is interfered with by the use of arsenic, nausea or inappetence produced, it generally does no good often harm. In such instances, preparing the stomach beforehand, changing the diet, disgoring the liver, giving attention to the patient's personal habits will allow the remedy to exert an influence, where unaided it would be without value or even harmful. The same remarks apply exactly to the administration of cod-liver oil, and often to the use of iron and other tonics.

The different preparations of arsenic may be called into play here in selected cases. I have more than once taken a patient with chronic psoriasis, who had hopelessly given up the digestion, and seemed to irritate his skin, and conducted him to a cure by combing arsenious acid with nuxvomica and pepsin, with some changes in diet, or by substituting the arsenite of soda for the arsenite of potash. The Bourboule water, a mild solution of the arsenite of soda, is a very gentle way of administering arsenic; too gentle as a rule, but yet I believe often effective of good, particularly in the case of weak digestion. Fowler's solution, especially if it has been long prepared, is very likely to disagree with digestion, and for this reason I seldom use it.

The more diffused, generalized and chronic that a given cutaneous malady is, the greater do I consider the indication for the use of a suitable preparation of arsenic, if the stomach will take it kindly. The more localized an affection is, be it ever so chronic, the less indication is there for arsenic in a general way, in my opinion.

Generalized chroma eczema, generalized psoria-

sis, and pemphigus may, perhaps, be selected as the maladies in which arsenic may be expected to exert what may be termed a certain specific general effect in controlling the symptoms—exceptions to the contrary notwithstanding. Yet the combination of mild doses of arsenic with other remedies is not without value in some localized maladies, and in combating some forms of acne and some cutaneous manifestations of syphilis. Much also might be said, but more cautiously, in the case of neurotic maladies as affecting the skin, and where an element of nervous debility keeps down the patient's general vitality, and prevents other suitable remedies from being effective.

In short, I think that there is so much value in the intelligent use of arsenic that it seems a sin to allow its association with that time-honored humbug, permiscuous blood letting, as an appropriate analogy to pass unchallenged.—*Journal of Cutaneous and Venereal Diseases.*

ON THE VALUE OF BORIC ACID IN VARIOUS CONDITIONS OF THE MOUTH.

BY A. D. MACGREGOR, M.B., KIRKALDY.

Boric acid is now officinal, and justly so. It has long been used in various metallurgical and ceramic operations, and more recently its preservative power has been abundantly demonstrated. It is this antiseptic power which gives it its great therapeutic value. It is a very stable compound—one of the most stable of the acids; it is not volatile, and only exerts its action when in solution; fortunately, however, it is soluble in more than one menstruum. Up till now its chief application has been in connection with modern surgery, where the boric ointment, lint, and lotions all hold a prominent place. There are spheres of usefulness for it, too, in medicine; and one of these is in diseases of the mouth. It is the benefit of its local action we usually wish to gain, for, though sometimes given internally—as in irritable conditions of the bladder—its topical antiseptic effect is more often desired. In connection with its local application in various diseased conditions of the mouth, its solubility in water and glycerine, its unirritating character, its comparatively innocuous nature, and its almost tastelessness, are greatly in its favor. More particularly is this the case in treating such conditions in children, whose oral cavities cause them so much annoyance. Speaking generally, boric acid will be found useful in all conditions of the mouth, fauces, pharynx and nose, where there is any abrasion of the epithelium; whether it be used as a powder, gargle, mouth-wash, pigment or confection. More definitely, I may say, it is not contra-indicated in any of the forms of *stomatitis*, though scarcely severe enough for the graver varieties.

In *simple catarrhal stomatitis*, a mouth-wash, containing from 10 to 15 grains to the fluid ounce, speedily cures the condition, and exercises the same beneficial influence in the *ulcerative* form,

though there, in addition to the rinsing of the mouth, a local application in the form of the powder or pigment should be made to the individual follicular ulcers. The powder simply consists of finely powdered boric acid, mixed in various proportions with starch; the pigment is a solution of boric acid in glycerine (1 in 4 or 5). In both cases the addition of chlorate of potassium is advantageous; indeed, I usually combine it, but it is not essential.

Nothing I know of is at once so rapid and so efficient, in the treatment of *parasitic stomatitis* or *thrush*, as this remedy. The youngest children do not object to its application, and occasionally you have to caution against its too frequent use. The *oidium albicans* quickly succumbs to its influence, I am well aware of the great value of nitrate of silver in many of these conditions; but, I am also alive to its extremely disagreeable and persistent taste, and the dislike which precocious children at once take to it. For thrush in children, I especially recommend boric acid, either as a mouth-pigment or as a confection. Honey and sugar have both been condemned as being inadmissible, in combination, for the treatment of thrush; but so far as children are concerned, I must say I consider a confection (though made with honey), which has been impregnated with boric acid, gains more by its palatableness than it loses by the tendency of the saccharine matter to further the growth of the fungus. The boric acid at once does away with this tendency. Let the pigment be frequently painted with a brush over the patches, never omitting to do it after food has been taken; or, a little of the confection simply allowed to dissolve in the mouth; and the days of the fungus will soon be ended. I have found boric acid combined with its salt (borax) markedly beneficial. Borax alone, however, is not nearly so good.

In *pharyngitis* and *relaxed conditions of the throat* a gargle, containing boric acid and glycerine with either tannic acid or alum in addition, ought not to be forgotten.

Let me allude to another condition, in which I have found combinations of this substance helpful and grateful to the patient. I refer to the condition in which we frequently find the mouth, tongue and teeth in severe cases of typhoid fever. The mouth is hot; the lips dry, cracked, and glued to the sordes-covered teeth by inspissated mucus and saliva; the tongue dry, or even glazed and hard, brown or black, crusted with a foetid fur. Under such circumstances, a pigment containing boric acid (30 grains), chlorate of potassium (20 grains), lemon juice (5 fluid drachms), and glycerine (3 fluid drachms), yields very comforting results. When the teeth are well rubbed with this, the sordes quickly and easily become detached, little harm will follow from the acid present. The boric acid attacks the masses of bacilli and bacteria; the chlorate of potassium cools and soothes the mucous membrane; the glycerine and lemon

juice moisten the parts, and aid the salivary secretion. I consider the application well worth a trial.

So much for the soft parts; a word in conclusion regarding the teeth. Few medical men, I suppose have ever given a prescription for a tooth-powder (such a matter is beneath their notice); and the selection of the ingredients for the various powders and pastes in vogue for the purpose of beautifying and cleansing the teeth is left entirely in the hands of those who certainly should not know better than medical men. I have frequently trespassed on this debatable ground, and recommend a particular dentifrice. In view of the extremely important part the teeth play in the economy of life, I never hesitate occasionally to inquire as to the attention they receive.

A tooth-powder should possess certain characteristics; it should be antiseptic, cooling, agreeable to taste and smell, and have no injurious action on the teeth. After use, it should leave the teeth white, and a sensation of freshness and cleanliness in the mouth. As an antiseptic in this connection nothing can displace boric acid. For years I have used the following powder, and can recommend it: Boric acid, finely powdered, 40 grs.; chlorate of potassium, 3 ss; powdered guaiacum, 20 grs.; prepared chalk, 3 i, powdered carbonate of magnesia, ʒ i; attar of roses, half a drop. The boric acid in solution gets between the teeth and the edges of the gums, and there it discharges its antiseptic functions; the chlorate and guaiacum contribute their quota to the benefit of the gums and mucous membrane generally; the chalk is the insoluble powder to detach the particles of tartar which may be present, and the magnesia the more soluble soft powder which can not harm the softest enamel.

It is only right to say that boroglyceride (Barff) can replace boric acid in almost all the forms of administration I have enumerated; it is efficacious slightly, and pleasant to the taste.—*British Medical Journal*.

SOME APHORISMS IN OPHTHALMOLOGY.

By M. F. COOMES, M.D.

1. As a local anesthetic to mucous surfaces and open wounds, the muriate of cocaine is one of the most certain and effective agents that is known.
2. All surgical operations on the eye, except enucleation of the globe, may be performed under the influence of cocaine with as much or more safety than under any other anesthetics.
3. In all forms of iritis keep the pupil dilated.
4. In acute retinitis, unaccompanied by iritis, keep the pupil contracted, in order to keep out as much light as possible.
5. The only relief for senile cataract is surgical interference.
6. The rule is that all acute purulent discharges from the conjunctiva are contagious.

7. The only proper method of testing the vision in persons possessing the power of accommodation is to suspend that power by paralyzing it, and then pursue the usual method with the trial lenses.

8. Jequirity is a dangerous remedy as well as an unreliable one, and should not be used by unskilled persons.

9. All kinds of strong caustic applications are contra-indicated in the treatment of acute purulent inflammations of the conjunctiva.

The best results are obtained by frequent cleansing with mild saline solutions, and the use of weak solutions of the vegetable or mineral astrigents (excluding nitrate of silver), a solution containing five grains of tannic acid and three grains of carbolic acid to the ounce of water, or from one-half to one grain of the sulphate of copper to the ounce of water will be found among the most efficient agents.

10. It is always good surgery to remove a foreign body from the eye, provided it is not entirely within the globe behind the iris. If the foreign body is between the iris and the cornea, prompt removal is urgently demanded.

Great care must be taken in order to avoid wounding the lens, as such an accident would be certain to result in the production of cataract. If the foreign body should be entirely within the globe behind the iris, or if it should be large and partially within the globe, the question to be settled is, whether it will be best to remove the eye or the foreign body.

If the laceration of the globe is not too great it will probably be best to remove the foreign body; and then if the globe becomes violently inflamed, or if sympathetic inflammation of the other eye should occur, remove the diseased member without delay.

11. An eye-ball that is destroyed for visual purposes, and is painful, should be removed without delay, as it may induce inflammation in the good eye, and result in its destruction.

12. Whenever there is one or more small nodules about the margin of the pupil or in the iris in case of iritis, it is almost absolute evidence that the disease is syphilitic.

13. The operation of strabotomy should be performed, if possible, without general anesthesia, because its influence so relaxes the muscular system that it is impossible to determine when the operation is completed.

14. When the iris is wounded and is protruding it should be cut off, and the eye kept under the influence of a mydriatic until the inflammation has subsided.

15. An unskilled person should never attempt to replace a protruding iris, as such a procedure is difficult, and there is great danger of injuring the lens and inducing cataract.

16. Surgical interference is the only means of giving permanent relief to glaucoma. Eserino will give temporary relief, and cocaine relieves the pain for a short time.

17. One of the most efficient agents in tenia-tarsi is an ointment composed of ten or fifteen grains of the yellow oxide of mercury to one-half ounce of simple cerate, or some other suitable article. This is to be applied to the lids night and morning, after thorough cleansing.

18. Poultices of every description are to be avoided in diseases of the eye, unless ordered by some one who is specially skilled in this line of practice.

19. Whenever there is great edema of the conjunctiva, and particularly when this is associated with excessive purulent discharge, the membrane should be snipped in numerous places so as to permit the pent-up fluid to escape, and thus prevent destruction of the cornea, which is always in danger in such cases. Remember that there can be no harm done by this cutting, and if it does not give the desired relief, a tarsarophy should be done.

20. In the majority of cases of strabismus, glasses are necessary as well as tenotomy, inasmuch as the strabismus in most instances is dependent on an optical defect which, if uncorrected, would cause a return of the squint.

21. It is always better to correct squint by means of properly adjusted lens than by tenotomy. —*Med. Herald.*

PROFESSOR HUXLEY ON SMOKING.

At a certain debate on smoking among the members of the British Association, Professor Huxley told the story of his struggles in a way which utterly put the anti-tobacconists to confusion.

"For forty years of my life," said he, "tobacco had been a deadly poison to me. [Loud cheers from the anti-tobacconists.] In my youth, as a medical student, I tried to smoke. In vain! At every fresh attempt my insidious foe stretched me prostrate on the floor. [Repeated cheers.] I entered the navy. Again I tried to smoke, and again met with defeat. I hated tobacco. I could have almost lent my support to any institution that had for its object the putting of tobacco smokers to death. [Vociferous cheering.] A few years ago I was in Brittainy with some friends; we went to an inn; they began to smoke and looked very happy, and outside it was very wet and dismal. I thought I would try a cigar. [Murmurs]

I did so. [Great expectations.] I smoked that cigar—it was delicious! [Groans.] From that moment I was a changed man, and now I feel that smoking in moderation is a comfortable and laudable practice, and is productive of good.

[Dismay and confusion of the anti-tobacconists. Roars of laughter from the smokers.] There is no more harm in a pipe than there is in a cup of tea. You may poison yourself by drinking too much green tea, and kill yourself by eating too many beefsteaks. For my own part, I consider that tobacco, in moderation, is a sweetener and equalizer of the temper." [Total rout of the anti-tobacconists, and complete triumph of the smokers.]—*Medical and Surgical Reporter.*

IODIDE POTASSIUM IN SPASMODIC ASTHMA.

BY J. A. ORMEROD, M.D.

Although iodide potassium is well known as a remedy for spasmodic asthma, it is a remedy which seems to be held in very varying estimation. Some authorities speak of it as a specific, others say it is worth a trial, others do not mention it at all. I have 36 cases of asthma treated by me, as out-patients, with this drug. All of them displayed, though with varying severity, the cardinal symptoms of the disease, viz., difficulty of breathing, coming on suddenly, usually in the early morning during sleep, passing off after a time so as to leave the patient comparatively well, but recurring usually in a regular fashion, and at regular intervals.

Whatever be thought of the pathology of the disease, its existence as a symptomatic entity is undoubted. And I think that inferences concerning the effect on it of a simple drug like iod. pot. may fairly be drawn from outpatient practice; for (1) though the physician may not witness the spasm, the sufferer is as well qualified as any one to tell of its frequency and severity, and (2) the patient is treated without change of his every-day surroundings, a change which frequently is of itself sufficient to modify this disease.

I have endeavored to classify the cases as follows: [The writer gives several pages in tabular form showing result of treatment, etc.] Asthma for the most part uncomplicated. Asthma with bronchitis or emphysema; the relation between the two being doubtful. Asthma with secondary emphysema. Asthma secondary to bronchitis or emphysema.

But unless the disease be watched from the beginning and over a length of time, and the physician be able to examine the chest both between and during the spasms, it is difficult to say into which category a case should go.

The iodide was given alone, or if in combination only after the effect of the uncombined drug had been watched. It proved a failure in nine out of the 36 cases, *i.e.*, only in 25 per cent. Its good effects (with a limitation to be mentioned presently) were not limited to the uncomplicated cases. The cases where the asthma appeared to be distinctly secondary to chronic lung disease are indeed too few to say much about; but in some of them at least it did good. The symptoms most amenable to the drug were certainly the nocturnal attacks of dyspnoea; its effect on them was often remarkable; thus in many cases they disappeared altogether; in others they were much reduced in frequency and severity. But a troublesome cough, or certain shortness of breath on rising in the morning, often persisted. That the nocturnal attacks were really controlled by the iodide was shown by the fact that they recurred (in many cases) whenever the drug was stopped. It has therefore the effect of relieving rather than curing. Five or 10 grains three times a day suited best in most cases; in some a larger or smaller dose did better. In some an increase of the

dose did good for a time, but the effect seemed to wear off.

The condition of the nasal mucous membrane contributes, it is said, to the production of asthmatic attacks; and iodine might therefore be thought to act by producing coryza; but coryza occurred in very few of the patients thus treated. In one case the attacks had been preceded by coryza, and they were nevertheless stopped by iodide.

Syphilitic taint has never, so far as I know, been alleged as the cause of asthma. In one case the substituted mercury for the iodide, and a relapse immediately followed.

The gouty diathesis is an undoubted cause of asthma, and iod. pot. is known to be useful in cases of gout. But the promptitude of its effect on spasmodic attacks of asthma, and the promptitude of the relapse when it is stopped, makes it unlikely. I think, that it acts by modifying the general condition of the patient.

I believe that its action may be fairly compared to that of bromide in epilepsy. The chemical similarity of the drugs is obvious. There are similarities also between the two diseases; both are characterized by attacks which recur periodically and often with considerable regularity, and which leave intervals of tolerable health. Epilepsy often begins in the night, as asthma does still more frequently. Asthmatic attacks may be preceded by a kind of warning. Both diseases are probably due to some fault in the central nervous system, though in both extrinsic causes may determine an attack.—*Practitioner.*

HYDROCHLORATE OF COCAINE IN THE VOMITING OF PREGNANCY.

Weiss of Prague, has used this remedy successfully in a case of vomiting in pregnancy which had resisted all previous attempts at relief. The patient was weak and anemic, of a nervous disposition, and had suffered in three different pregnancies from persistent vomiting; in the present pregnancy her condition was serious. Weiss prescribed:

R Hydrochlorate of cocaine.....gr. ij
Alcohol, enough to dissolve
Water..... ʒ v.

S: One teaspoonful every half hour.

After the sixth dose three tablespoonfuls of milk were well borne; after the eighth, a cup of broth with egg, without vomiting. After the sixteenth dose the patient ate with relish chicken broth, slices of white chicken meat, and drank a glass of wine without vomiting. The drug was then withdrawn for a time, owing to an increased frequency of pulse and respiration; but hourly doses were subsequently given, with the result of entirely checking the vomiting and enabling the patient to regain her former strength.—*Edinburgh Medical Journal.*

THE DIAGNOSIS OF ORGANIC HEART TROUBLES.

BY EMORY LANPHEAR, KANSAS CITY, MO.

There are no problems of physical diagnosis which so puzzle the average practitioner as differentiating between, and recognizing the significance of, the murmurs present in organic diseases of the heart.

It is quite evident that proper therapeutic agents cannot be employed until an exact knowledge of the conditions present in any particular case can be obtained by the attending physician. In most cardiac affections attended by organic change there are distinct murmurs discoverable, and it is only by a proper understanding of these morbid sounds that an accurate diagnosis can be made. Therefore, any guide to their meaning must be acceptable to the majority of the medical profession. To those who hear, but fail to appreciate the precise meaning of these sounds, the subjoined table will prove invaluable.

I am indebted to my friend, Prof. A. B. Shaw, of St. Louis, for this table, he having presented it to the class at the Missouri Medical College in the spring of 1879. Many complex tables have been given to the profession, but this is probably the best, combining, as it does, simplicity with easiness of remembrance; yet comprising all that is needed in making stethoscopic examination of the heart stating perfectly the time and location of the murmur, thus indicating what the lesion is, and where it is located. I submit it to the readers of this article, trusting it may prove of as much benefit to them as it has to me:

TABLE OF CARDIAC MURMURS.

WHERE HEARD.	TIME OF MURMUR.	SIGNIFICANCE.
Apex.	Systolic.	Mitral Regurgitation.
Base of Heart and ascending Aorta.	Pre-Systolic.	Mitral Obstruction or Direct Mitral.
	Systolic.	Aortic Obstruction or Direct Aortic.
Base of Heart, conducted toward Ensiform Cartilage.	Diastolic.	Aortic Regurgitation.
	Systolic.	Tricuspid Regurgitation.
Base, conjoined with Jugular Pulsation.	Systolic.	Pulmonary Obstruction.
	Diastolic.	Pulmonary Regurgitation.
Region of Pulmonary Artery.		

Pages might be written explanatory of this table; in fact, it covers the whole subject of the diagnosis of organic diseases of the heart. With it, all that is necessary is a knowledge of the topographical anatomy of the præcordial region; the location of various structures mentioned being known, and the several murmurs being heard, all that remains is to distinguish between systolic and diastolic sounds, and the diagnosis is accomplished. Without some such table in one's mind, it is impossible to intelligently examine a chest for cardiac trouble.—*Kansas City Medical Index.*

SHALL PATIENT EAT WHAT HE CRAVES?

I often notice in medical journals, and hear it talked by medical men, that people should eat whatever the appetite, that being the true guide to the wants of the system, craves. In theory this may be right, based upon a normal appetite. (Who has one?) but in practice I believe it decidedly wrong.

Whenever we find a person craving some article of food or drink, and we can satisfy ourselves that it is a demand of nature for a needed supply, give it by all means. But there are so many perverted appetites, cravings and desires, that one must discriminate very closely, and think in straight lines, or he will err, and do harm to the body and life.

Country doctors do so little thinking as a rule, that advocates and teachers should be very careful what they teach. Who has not seen an old toper crave his whiskey, an old smoker his tobacco, an opium eater his drug, or a dyspeptic whose secretions are so loaded with lactic acid and the mucus membrane of whose mouth, stomach and bowels is so irritated by it, that functions can not be properly performed at all, and still craving and eating pickles, lemons and other sharp acids, etc. Any number of examples might be given, and yet doctors will often tell the patients to eat and drink what the appetite craves. When will medical men learn to think and try to understand vital processes, and realise that disease is not an entity but merely perverted life. This thought might be carried on into the realm of medicine, as well as food, its uses and abuses. There is a field here for both thought and experiment.

E. P. WHITFORD, M.D.

DROPS FOR EARACHE.

Pavesi recommends a mixture of camphor chloral 2½ parts, glycerine 16½ parts, and oil of almonds 10 parts. This is to be well mixed and kept in a well-closed bottle. A pledget of absorbent cotton is to be soaked with the drops, and then introduced as far as possible into the affected ear, two applications being made daily. Frictions may also be made each day with the preparation behind the ear. The pain is almost immediately relieved.

URINARY INCONTINENCE OF CHILDREN TREATED BY ANODYNES PER RECTUM.

Dr. Edward T. Williams thus writes in the *Boston and M. & S. Jour*:

It is safe to say that the modes of treatment usually recommended for this distressing infirmity are frequently ineffective and disappointing. A failure of my own some years ago, with a child nearly related and especially dear to me, led me to cast about for some improved method. For the past year or two I have been trying, with complete success thus far, the use of anodynes by the rectum, in the form of injections and suppositories of morphine, belladonna or atropine. I have now cured about six cases by this means, besides temporarily relieving many, more who have passed out of sight during treatment, so that I cannot positively state the final results. I have no doubt, though, that a portion of these have been cured. Some of them were patients of the Sea Shore Home, where the length of stay averages less than a fortnight—too short a time to effect a permanent cure in any case. One of my cases, which I will describe presently in detail, had been a constant sufferer for ten years. The treatment occupied a year, off and on. She is now entirely well.

I find that morphine alone relieves for the time being, but does not cure. Belladonna and atropine are curative, when continued long enough, though I find them to be better borne in combination with a little morphine, which counteracts some of their bad effects, and enables them to be given more continuously. Furthermore, the requisite dose of belladonna is smaller when combined with morphine. When these medicines produce headache or undue nervous excitability, I use the bromides as a corrective, or suspend their administration for a time. I have found no case where they could not be borne when properly given.

As to the mode of administration, a fifteen grain suppository of cocoa butter is most easily handled, and that which I prefer. They should contain a proper amount of extract of belladonna and morphine. For a child five years old, say one-eighth of a grain of belladonna extract, and one-sixteenth grain of morphine; but the doses must be carefully adapted to the particular case in hand, beginning with a small dose, with a smaller relative proportion of belladonna, and increasing the latter and diminishing the morphine as toleration becomes established.

If an enema or clyster be preferred, it should consist of about a drachm of lukewarm water, with a few drops of atropia and morphine solution added, and administered with the small hard-rubber syringe (No. 2) especially designed for the purpose. The old fashioned clyster of starch-water and laudanum is absurdly out of date. I have used nothing for years but morphine and warm water, mixed as for a subcutaneous injection, only that the water should be tepid, and not exceeding a drachm in amount.

I hardly dare claim to be the originator of this self-suggestive plan, though I certainly never heard of its being done by others before I adopted it out of my own fancy years ago, since which time I have freely mentioned it in conversation and before various societies. It is certainly the simplest form of anodyne clyster.

At the Sea Shore Home, where we do things by wholesale, I have two solutions of morphine and atropia ready made. The first consists of one-sixth grain of morphine and twenty minims of water. The dose by drops therefrom is the same as that of laudanum, which makes it especially convenient for the nurses. The other is one-sixtieth grain of atropine to twenty minims of water. Reckoning one-sixtieth of a grain as an average commencing dose for an adult, the dose for a child may be graduated by drops precisely as with laudanum. For a child five years old, then, as an enema, you might give for a commencing dose from three to five drops of each solution, mixed with a teaspoonful of warm water. These doses may be differently combined or altered in any way to suit a particular case.

I mention these points because it is convenient to have both in private and hospital practice certain methods of routine, not only to save thought and labor, but to lessen the chances of mistake.

I will conclude by recounting a single case as an illustration of this mode of treatment. A bright and charmingly pretty girl of fourteen came under my care for this disease July, 9, 1883. Had been subject to it for years, in fact nearly all her life. Was of a peculiarly sensitive, nervous temperament, and subject to convulsions in infancy and early childhood, for which I had myself attended her. Was just beginning to menstruate. The urinary trouble had become a great source of mortification to her, and her shyness about it was so great that she could not be brought to talk with me on the subject, so that all communication had to pass through the mother, a thing I should hardly have put up with if it had not been one of my particular families. This being my first case (of rectal treatment) I began with morphine alone, one-sixth of a grain nightly, in suppository. Failing to produce full relief I doubled the strength, making one-third of a grain, when she went nearly a month without once wetting the bed. On stopping the suppository the trouble quickly returned. Recommenced the one-third grain suppository on September 14th, with full relief of the incontinence as before, but the patient, who was attending school all the time, began to get "fidgety" and nervous from the effects of the morphine, so that I was compelled to give small doses of bromide of potassium daily. This relieved the nervous symptoms entirely. I then began to taper off on the morphine, giving a suppository every second or third night instead of every night, or occasionally halving the suppository. On this treatment she began to wet more frequently, and I became satisfied that morphine alone would not cure her. October 29th I prescribed a suppository

containing one-sixth grain of morphine and one-fourth grain extract of belladonna. On December 10th I made it one-eighth grain morphine and one-half grain extract of belladonna. Both these answered perfectly, and in six weeks she was practically cured. In the succeeding six months she did not wet more than six times, but each time was carefully followed by the use of the belladonna suppository for one week to prevent a relapse. For two years now, since the summer of 1884, she has been perfectly well, and improved greatly in general health.

I might report other cases far more rapidly cured. I select the above on account of its long standing, and, since I was obliged to proceed somewhat tentatively, as showing very well the comparative action of morphine and belladonna. The latter I have never given without some morphine, believing they act better in combination, as they do when given by the mouth.

From my present experience I regard the rectal treatment as superior to all others in this disease.

THE SURGICAL TREATMENT OF SUBIN- VOLUTION.

Dr. A. Palmer Dudley thus writes in the *N. Y. Med. Jour.*, September 4 :

"These patients were at once put upon the use of hot vaginal injections twice daily. If there was cystic degeneration of the cervix, all of the cysts that could be reached were tapped. If the os and cervical endometrium were granular, appropriate treatment for it was given; and applications of Churchill's tincture of iodine to the cervix and vaginal roof, together with glycerine tampons, were used in some cases as often as every other day. That this method of treatment was beneficial no one for a moment could doubt, but it did not cure my patients. It did not relieve the weight and dragging pains, or do away with the foul leucorrhœal discharges of which the patients had so long complained.

"After each patient had been kept under this form of treatment for a certain time, she was put under an anæsthetic, and the depth of the womb carefully noted. If menorrhagia had been her habit, the cervix was rapidly dilated and the endometrium carefully but thoroughly curetted with Bozeman's curette, and then touched with a 1 to 2,000 solution of bichloride of mercury, wiped dry, and again touched with glycerite of carbolic acid. Many prefer the use of Churchill's tincture of iodine for this purpose, believing it more efficacious in preventing a return of the fungosities; but, in cases where the cervix is to be operated upon, the use of the iodine is disadvantageous, on account of its discoloring the parts and rendering the operation more difficult. After this treatment of the endometrium, if the cervix was lacerated, I

operated for its closure after Emmet's method, going deep into the angles of the laceration. If the cervix was not lacerated, I operated after the following manner: I steadied the cervix with a heavy, curved tenaculum, and, with a pair of sharp narrow-bladed scissors, I made a deep, narrow V-shaped incision in each side of the cervix, extending the incision, if possible, deep enough into the uterine tissue to sever what we ordinarily style the circular artery. Then, after letting the incisions bleed quite thoroughly, I closed the wound by passing sutures from without inward across the incision, taking care that the first sutures ligated the several vessels. After the operation, warm water vaginal injections were used for cleanliness only. If the uterus was retroverted, a pessary was fitted and allowed to remain in position while the wound was healing."

The results were satisfactory.

THE MILK TREATMENT.

T. A. McBRIDE, M.D., NEW YORK.

The patient is to use *skimmed* milk, and *skimmed* milk alone; no other kind of nourishment.

The patient is to take, three or four times daily, and at regularly observed intervals, from two to six ounces of skimmed milk.

This must be taken slowly, and in small quantities, so that the saliva may be well mixed with it. The reaction of the milk to test paper must be neutral or alkaline.

The first week is the most difficult to get over, unless the patient has a strong will.

During the second week two ordinary quarts may be consumed during the day. The milk must be drunk four times daily; at 8 a.m., at noon, at 4 and 8 p.m. The hours may be changed, but regular intervals must be maintained.

If the patient comply with these directions he will complain neither of hunger or thirst, although the first doses appear so very small.

The daily quantity may be increased to eighty or more ounces.

If after having attained this quantity or more, and the patient gets worse, diminish the amount to the quantity used the first week, and increase more slowly.

Constipation at the beginning is a good sign. This may be remedied by warm water injections, or by the use of castor oil, rhubarb, addition of sugar of milk to the milk, or by taking some bicarbonate of soda at bed-time. If the constipation be obstinate, a little coffee may be added to the morning dose of milk, or towards 4 p.m., stewed prunes or a roasted apple.

If, on the other hand, diarrhœa result, and rumbling of the bowels is frequent, the milk is too rich or is being taken in too large doses.

Feverishness is no contra-indication to its use. If the patient is very thirsty he may drink Clismic, Bethesda, Poland or Vichy Water. If he have a strong desire for solid food at the end of the second or third week, he may have a little stale white bread or toasted bread with salt, in the morning and again at 4 p.m. Once a day he may have some soup made of milk and oatmeal.

After continuing this treatment for five or six weeks it may be modified, by allowing the milk only thrice daily, and once a day steak or a chop. Raw meat digests most easily, and should be used in preference to the cooked, when possible.

It may be necessary to add a little salt to the milk in some cases, and in others to have the milk drunk when very hot. If the patient become flatulent, buttermilk is often beneficial in small quantities.

THE TREATMENT OF SCALP WOUNDS AT THE CHAMBERS STREET HOSPITAL.

Dr. C. R. Parke, in an article published recently in the *New York Medical Journal*, makes the following statements :

Our present method of treating a scalp wound is as follows : Upon admission of the patient, the wound and bloody hair are thoroughly cleansed with a douche of the hydronaphthol solution, next the hair is carefully cut with scissors for about one inch around the margins of the wound, after which it is cleanly shaved ; the wound is now again cleansed with the hydronaphthol, all clots and foreign bodies being removed, and careful examination for fracture made. This now being found, we proceed to the dressing, which consists in inserting ten or twelve horse hairs through the bottom of the wound, the opposing edges of the wound being carefully approximated and sewn together with catgut sutures, the horse hair projecting about three-fourths of an inch beyond the ends of the wound and thus acting as an excellent drain. The wound is now again washed with the hydro-naphthol, and powdered iodiform lightly dusted over the line of the sutures, upon which are applied a few layers of iodiform gauze ; over this is placed a large compress of absorbent gauze, extending several inches beyond the wound on every side, the whole being held in place by a bandage, the style of which depends upon the location of the injury. The patient is told to return in two days, provided no pain or unlooked-for symptoms arise, under which circumstances he is requested to return at once. Upon returning two days later, as a rule, we find primary union throughout the entire length of the wound, excepting at the ends where the drain protrudes. We have now converted the open scalp wound into a perfectly drained sinus. All but three or four of the horse hairs are removed, the sinus is irrigated with the hydronaphthol solution, and the same style of dressing re-applied.

In two or three days more the sinus has so narrowed down that the remaining horse hairs can with safety be withdrawn, and complete healing can occur under the dressing then applied ; the catgut sutures are absorbed and give rise to no trouble. The wound thus heals with little or no scar, as compared with the plan which allows the wound to granulate from the bottom, and furthermore offers the advantage of healing in a much shorter time. The virtues which I maintain for the hydronaphthol solution over those possessed by the carbolic acid and bichloride solutions are that it is without odor, and does not burn or discolor the hands as carbolic acid does, neither does it ruin one's instruments nor cause any danger from absorption, as if the case with the bichloride, while at the same time it is a perfect deodorizer, non-irritant, and, as I think, a desinfectant.

In order to give a little idea of the results we obtain under this method of treatment, I took at random 30 out of the 123 cases treated here in thirty days and carefully looked the patients up ; five of them never returned after the first dressing was applied. Of twenty-five there was a full record until they were discharged cured. The longest period that any patient was under treatment was ten days, and the shortest three days, the average being six *plus*. The greatest number of dressings employed in any case was six, and the smallest two, the average being three *plus*.

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by looking at the label on his Record. We regret to say that a great many are very far in arrear. Will *all* our subscribers look at their label, and remit to us what is necessary.

PERSONAL.

Dr. Longeway, (M.D., Bishop's College, 1886,) has removed from Highgate, Vermont, to Montreal, where he has commenced practice. He has also been appointed an Assistant Demonstrator of Anatomy, in the Medical Faculty of his Alma Mater.

Dr. Freleigh, M.D., Bishops' College, 1886, has commenced practice in Montreal.

Dr. McCow, M.D., McGill, 1886, has commenced practice in Montreal.

Dr. Schmidt, M.D., McGill College, 1886, has settled in Montreal.

Dr. Wood, M.D., McGill, 1876, has returned from Florida and commenced practice in St. Johns, Que.

REVIEWS.

The healing of arteries after ligature in man and animals. By J. COLLINS WARREN, M.D., Assistant Professor of Surgery, Harvard University; Surgeon to the Massachusetts General Hospital; Member American Surgical Association; Honorary Fellow Philadelphia Academy of Surgery. One Volume. 184 Pages. Superbly illustrated with Twelve Full-page Plates in Black and Colors. Parchment Muslin Binding. Price \$3.25. William Wood and Company, New York.

The great facilities afforded the author have enabled him to present to the profession a monograph at once comprehensive and original. The importance of the subject to the surgeon is evident and though much has been written elsewhere the author, while not discarding the labors of others, arrives at conclusion based upon his own observations and, therefore, valuable. The work is rendered more valuable by the excellent plates which illustrate the different phases through which the vessel passes after ligation and until no further change occurs.

Separate chapters are devoted to the history of the ligature, experiments on animals, the ligature of arteries in man, as shown by specimens from the different museum, closure of foetal vessels. The summary on chapter fifth includes his conclusions

and an appendix describing the methods employed in these investigations. A Bibliography containing 235 references and an index complete the volume.

The Physician's Pocket Day-Book. By C. HENRI LEONARD, M.A., M.D., Detroit, Mich. Price \$1.00.

This is a very convenient form of visiting list, and accommodates daily charges for 25 or 50 families weekly, an obstetrical record and Dr. and Cr. cash account. For the young physicians commencing practice it will be found one of the best diaries extant, as it serves the purpose of day book and ledger combined. It is arranged for 13 months, and the record may begin at any month of the year.

A Laboratory Guide, in Urmalysis and Toxicology. By R. A. WITHAM, A.M., M.D., professor of Chemistry and Physics, University of the city of New York, etc. Wm. Wood & Co., New York.

A concise and practical guide, very suitable for laboratory work, is every alternate page left blank for the purpose of entering additional notes. We commend this little work to the student or busy practitioner as a very useful aid for the purposes indicated.

Outlines of the Pathology and Treatment of Syphilis and allied venereal disease. By H. VON ZEISSL, M.D., late professor at the Imperial Royal University of Vienna, translated by H. Raphael, M. D., Bellevue hospital, one volume, 402 pages. D. Appleton & Company, New York.

This is a second edition of this work, the success of the first inducing a revision of the text, so as to make the description of venereal diseases as perfect as possible. The value of the work is attested by the fact that the author devoted a lifetime specially to the study and treatment of these affections. The descriptions are concise and graphic, prominence being given to the pathology of the structures concerned, and the remedies and formulas are such as have been found, by long clinical experience, to be best adapted for the treatment of the different phases of these diseases. Although the work offers but little that is new, still the practical physician, whose time does not permit the study of more extensive works, will find this a valuable aid in his practice.