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Original Communications.

ERYSIPELAS AND DOUBLE CEREBRAL ABSCESS.

By GEORGE E. ARMSTRONG, M. D., Professor of Physiology, University of Bishop's College, Montreal.

Read before the Medico-Chirurgical Society of Montreal.

Mr. PRESIDENT and GENTLEMEN,—Cerebral abscess, from whatever cause, being a comparatively rare disease, it falling to the lot of no man to see many cases, I think it well to report and place upon record a case that occurred in my practice a little more than a year ago.

From a pretty full daily record of the case taken at the time, I have taken the following report.

F. F., æt. 17 years, a well developed lad of average height and spare build, a student, was first seen Thursday, 15th February, 1883. Since the fall he has applied himself pretty constantly to his books, but has been in good health until about three (3) weeks ago, when he complained of indisposition to work; his appetite became capricious, and he suffered from headache, the pain being limited to the vertex. His family history is negative. Last Saturday, five (5) days before my first visit, he first noticed a small pimple on the right side of his nose. At my first visit he complained of severe pain in the top of his head. Complete anorexia. Bowels had moved naturally that morning. Tongue had a thin white coat. The bridge and both sides of the nose were red, swollen, hot, and painful, and on the right side was a large sebaceous follicle distended with pus, surrounded by several other ones in the same condition. These

were relieved of their contents by expression, and he was put upon treatment which included a liberal supply of nourishment and rest in bed.

During the two following days the erysipelas extended over both cheeks and upwards over the lower half of the forehead. There was very little constitutional disturbance, with the exception of the continuance of the pain in the top of the head.

18th. July.—Had a slight chill this morning at 9 o'clock. Pulse 92, T. 104; F. Headache continues, tongue pretty clean, a little nausea present but no vomiting, bowels not moved for two days, surface of body moist with perspiration. Erysipelas has not spread since last note. Heart and lungs normal. Hepatic and splenic dullness normal. Ordered a powder of Hydrarg. subchlor. and P. Jalapæ Co.

20th. Headache still continues very severe and remains limited to the vertex. The pain is so severe that he cannot rest or sleep. Finds some relief from an ice cap. The head and neck seem fixed and extended, and he is unable to bend his head forward. He answers correctly any question put to him, but speaks in a slow and drawing manner. Says he can hear nothing in right ear. There is no discharge from the ext. auditory meatus; a little pocket of pus has formed on right side of nose near right eye, which is opened freely. There is a good deal of œdema of the subconjunctival areolar tissue of the right eye. Bowels moved freely after the powder.

T. 100 F. and pulse very slow, only 56 beats in the minute. No chill and no sweating—Gave the right eye in charge of Dr. Proudfoot.

23rd., 10 a. m. P. 68. and intermittent, T. 103.5,

R. 30. Seen in consultation to-day by Dr. R. P. Howard. Dr. Howard agreed with me as to the gravity of the symptoms, and considered that the true nature of the nervous symptoms especially, was yet a doubtful question. I freely opened a pocket of pus situated in the middle line of the forehead between the two frontal eminences.

24th., 10 a. m. Passed a very restless night until 4-30 a. m. when he dropped off to sleep. A mild delirium is present. When questions are addressed to him, he sometimes answers them correctly and sometimes incorrectly, and sometimes will not reply at all—P. 80 when he is quiet, but if aroused it falls to 74.; T. 102. 6 F.—6 p. m. Has slept six hours since morning visit. Very little delirium during the day. Answers questions much more promptly than in the morning. Pupils normal and react to light. P. 64, T. 102. 5, R. 28. Opened a small collection of pus at root of nose below incision on forehead.

25th., 11 a. m. Has passed a good night, sleeping most of the time, very little delirium. P. 66 and regular, T. 101.8, R. 28. Takes plenty of beef-tea, and milk and eggs. Pus coming freely from both incisions in forehead. Answers questions rationally but a little slowly. Speech is thick.—8 30 p. m. There is noticed this evening a slight twitching of the arms and body. No paralysis of any muscle. Sensation normal.

26th. Condition same as yesterday. I gave exit to a collection of pus which pointed at the inner and upper angle of the right upper eye-lid.

27th. Feb. Condition unchanged. Incisions on forehead and root of nose quite healed up. I gave ether, and Dr. Proudfoot carried an incision back along the upper and inner angle of orbit quite to the apex. Considerable pus flowed out, and a tent of lint was introduced and a linseed meal poultice applied.

1st. March. Passed a very restless night, suffering intensely from the pain in his head. P. 54, T. 101. 8, R. 24.

6 p. m.. Has slept quietly nearly all day, being awakened occasionally for food and medicine. P. 56, R. 24.

3rd. Says he has no headache to-day, Answers more intelligently when spoken to.—Ear and face look much better. Still quite deaf in right ear. Emaciation is general and very noticeable. No chills and no sweating. P. 62, T. 99, R. 21.

5th. Since last note he has suffered intensely from paroxysms of headache, at times being with

difficulty retained in bed. His breathing is intermittent, and he is continually moaning. I have repeatedly stood beside him, watch in hand, for $\frac{3}{4}$ of a minute, without being able to detect any sign of respiration, then there would occur 2 or 3 quick short respirations followed again by this long intermission. Speaks intelligently when spoken to, but in a slow and drawling thick manner. This morning says he has no pain in his head, and that he had none during the night; can now bend his head forward a little. P. 80, T. 100. 4, R. 16. Dr. Howard saw him again to-day. Dr. Proudfoot examined the eyes to-day with the ophthalmoscope, and reported in the right eye a slight papillitis. No engorgement of vessels; 3 or 4 large veins were observed, but they were not tortuous; margin of disk a little indistinct on inner side. No pulsation of vessels visible.

8th. March. Slept a good deal last night. Complains of a little frontal headache. Moaning continues, no delirium; will follow an idea clearly for several minutes, but is becoming irritable. No chills or sweating, no paralysis. Bowels and bladder act regularly. Takes nourishment well, and retains it. Hands and feet cold—ordered extremities wrapped in cotton wool, and whiskey to be given internally. P. 60, T. 97. 8, R. 22.

10th. Vomited twice last night, very marked retraction of abdomen. Any slight exertion is followed by intermittent breathing. Emaciation is now extreme.

20th. March. Since last note his condition has been daily growing worse; vomiting has continued, and the right eye-ball has been daily becoming more prominent, evidently pushed forward by something behind it. Drs. Howard and Proudfoot met me to-day in consultation, and confirmed my opinion that pus had formed behind the eye-ball and was pushing it out. Ether was administered and three openings were made by Dr. Proudfoot, one along the sup. int. angle, one along the inf. int angle, and one along the inf. ext. angle of the orbit, each extending quite back to the apex. Considerable quantities of pus came from each opening made. It was the opinion at the time that the obstinate vomiting was reflex, and dependent upon the suppuration in the orbit. Pulse before the operation was 102, and after the effect of the anæsthetic had passed off the pulse was 50.

30th March.—Since last note patient has been in much the same condition as then reported. Vomiting continues. Emaciation progresses rapidly.

There is no headache and no delirium. Can see pretty well with right eye, which has receded to nearly the level of the other, and the incisions are healing from the bottom. Is still deaf in right ear. Can bend head forward.

The subsequent history of the case is simply that of gradual failure of the vital powers. Extreme emaciation, and death on the 14th April, 1883. Duration of illness, 8 weeks and 2 days.

In regard to the treatment there is nothing unusual to note. The Tinct. Ferri Mur. and Pot. Chlor. given in large doses. Quinine, grs. 5 or 10 were given night and morning, and the patient's strength supported by a liberal diet of concentrated and easily digested food. Stimulants were given very freely. I obtained great benefit in this case from the peptonized beef-tea and milk, giving them by the mouth, and when the vomiting began I gave them freely by the bowels, and they were generally very well retained.

At the necropsy only the contents of the calvaria and orbit were examined. The apex of the orbit and the parts in the immediate vicinity appeared normal. The membranes of the brain were normal with the exception of that portion of the dura-mater which covers the petrous portion of the right temporal bone. In this situation the dura-mater was of a very dark color, thickened and softened. The arachnoid and the pia-mater in this situation presenting a normal appearance.

The surface of the brain was everywhere of normal appearance. When the brain was turned over, pus was seen to issue from the under surface of the occipital lobe. Upon examining more carefully an abscess was found in each hemisphere, and similarly situated on either side. They occupied the centre of the occipital and part of the parietal lobes. They were not encysted. The pus was white and odourless. They were apparently confined to the central white matter, not involving the cortex. They were each about the size of an English walnut. The brain was so soft and friable that I was unable to determine with any degree of certainty whether the two abscesses communicated with the lateral ventricles and through them with each other.

The longitudinal sinuses were healthy. As to the etiology of the abscesses, I think there are two views of the case that might reasonably be taken. The first is that of a phlegmenous erysipelas of the face, causing a condition of pyæmia, with the cerebral abscesses as a result. In this

case the abscess would have been metastatic, as there was no extension backward into the cavity of the skull from the orbit, as in a case reported by Mair, and there was no post-mortem evidence of the inflammation being transmitted from the nasal to the cerebral cavity as in two cases mentioned by Gull. On the other hand, although, as stated by Hugnenin, "the absolute proof of the direct embolic orifice of an abscess of the brain, the accurate demonstration of the infectious embolus is still wanting, we find, nevertheless, important evidence of it in an observation of Boettchen. He found in the cavity of an abscess of the brain which was consecutive to abscess of the lung, a pigment which he was able to declare to be lung pigment." The fact of there being two abscesses, one in each hemisphere, would support the view of the abscess being embolic.

The second theory of the etiology of the abscesses is suggested by the finding of the dura covering the right tympanum in a necrosed condition, and by the continued deafness in the right ear. If this view of the cause be accepted, and Toynebee's law be applied, the disease would have been in the tympanum, which according to him stands in a relative connection with the cerebrum.

Gull, Sutton, Prescott Hewett, Wilks, Aitken, Hammond, and Agnew, all mention disease of the middle and internal ear as a common cause of abscess of the brain.

Hugnenin, the author of the article on encephalitis in Ziemssen, states that abscesses of the brain, which are secondary to affections of the ear, appear to be slightly more numerous than those which arise from injury. The fact of there being no perforation of the tympanum, and the fact of there being healthy brain substance between the bone and the abscess cavity, does not prove that the abscess was not the result of disease of the internal ear. Wilks says he has seen an abscess with a perfectly healthy portion of brain outside, and it was supposed that purulent inflammation had extended to it from the internal ear by means of a vein in the aquæductus vestibuli. That there was a meningitis in the upper cervical region causing the fixity and slight extension of the head, is very probable.

Many of the symptoms one usually looks for in cerebral abscesses were wanting, for example, with the exception of the slight twitching of the arms and legs on the 25th February, there was no

epileptiform seizure, no rigors. There was no paryalsis, either local or general, no incontinence of urine or fæces, no vertigo, no disordered sensibility, no defective sight, no coma. The prominent symptoms were severe headache, delirium, vomiting, a slow defective articulation, slow pulse and slow intermittent respiration. The last two symptoms were evidently due to the pressure of the abscesses on the brain, and simply denoted compression, which might be from any cause.

Gull and Sutton, who collected 76 cases for their article in Reynolds' System of Medicine, do not mention a slow pulse or slow respiration as occurring in any of them.

The absence of paralysis is explained by the matter being confined to the central white matter of the brain.

The erysipelas would then be regarded as an intercurrent affection.

ONTARIO MEDICAL ASSOCIATION MEETING.

The Canadian Practitioner says:—This Association held its Fourth Annual Meeting in Hamilton on the 4th and 5th of June. Although in point or numbers it fell behind its predecessors, in the amount of work accomplished, and in the harmony of feeling which pervaded its deliberations, it was far ahead of any previous meeting. The character of the papers read was decidedly above the average, and were pretty well distributed over the various sections of the country.

The president's address was replete with wit, and if some of his allusions were caustic, the application was so gentle, and administered with such a friendly smile, as to lose its sting. To the president's promptitude, and excellent qualities as a presiding officer, was due in a large measure the celerity with which the business of the Association was transacted without any appearance of hurry or confusion. Even with all the expedition, a number of papers were perforce read by title, and the Reports of Committees—some which were most excellent and contained matters of high interest to the Profession—were taken as read, or referred to the next Session.

The new President of the Association is Dr. Worthington, of Clinton.

London has been chosen as the next place of meeting.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 28th, 1884.

T. A. RODGER, M.D., IN THE CHAIR.

Fracture of the Femur.—The following is an abstract of a paper read by Dr. Jas. Bell on "Some Cases of Fracture of the Femur, treated by plaster-of-Paris splint." Three cases were reported, all occurring in children.

The first, a little boy 1½ years of age, with simple fracture in the middle third. The second, a boy four years of age, with fracture just below the trochanter from direct violence,—being run over by a heavily-laden cart.

The third case was that of a strong, healthy boy, aged 8 years, with fracture at the junction of the upper and middle thirds. In all these cases the treatment was the same. Ether was given, the limb extended, and the fragments brought into position, and held there until a plaster splint had been applied, extending from the toes and including the pelvis and loins. Coaptation splints of pasteboard were moulded to the leg and applied between the layers of plaster bandage.

In none of these cases has there been the slightest trouble of any kind, and in each case when the plaster was removed the union was found to be most satisfactory. In the first case there was no appreciable shortening. In the second about a quarter of an inch, and in the third a little over a quarter but less than half an inch. These cases were exhibited, as also an old man aged 62 years, who had a bad compound fracture of both tibia and fibula just above the ankle-joint. The fracture of the tibia had been oblique, and about three-quarters of an inch of the protruding fragment had to be removed with the saw before it could be reduced. The limb was then permanently fixed with plaster-of-Paris, leaving the wound exposed through the small opening in the bandage. The wound was dressed with Listerian precautions, and the patient was discharged at the end of eight weeks with a sound leg. He is now doing his regular work (six months after recovery), and has been for some time, without any inconvenience. The writer, in summing up, thought that in a great many cases

the plaster-of-Paris splint was the best that could be applied to a fractured femur, notably in children, in nervous and fidgety people, and in fractures complicated with delirium tremens, also among the poorer class of patients, where a suitable bed and good nursing (which are so essential in the ordinary treatment of extension) could not be secured. He also thought that objections urged against it for fracture of the femur were very much overrated.

Dr. GURD said that he would not like to risk treating an adult's fractured femur in this way, as he feared that before union had occurred there would be no pressure around the limb, owing to the rapid atrophy which follows disuse and bandaging, thus allowing displacement of the fractured ends.

Dr. BLACKADER said he had broken the femur of an infant with the blunt hook in a difficult breech case, and, assisted by Dr. Sutherland, a gutta-percha splint was applied, which answered admirably.

Dr. Sutherland said he was going to use plaster-of-Paris splints in these cases in the future.

Dr. SHEPHERD quoted Heath as saying that there was no necessity to take in the joints where plaster-of-Paris was employed.

Dr. RODGER had lately used plaster-of-Paris splint for fracture of the femur in a child aged 5 years, with excellent results. He always uses this method of treatment for fractures of tibia and fibula.

Cases in Practice.—Dr. BELL said that this evening he had been sent for by the Coroner to make a post-mortem examination on a young man, aged 28, who had been found dead in his bed. Death was found to have been caused by the bursting of a small aneurism into the pericardium. The aneurism arose from the lower and back part of the transverse portion of the arch. The young man had been treated as an out-door patient at the Hospital for pains in the back. Aneurism had not been detected.

Stated Meeting April 11th, 1884.

T. A. RODGER, M.D., in the chair.

Dr. TRENHOLME exhibited *two pairs of Ovaries and Tubes* lately removed. One case was operated on 22nd March. Both ovaries were much diseased, and enlarged to about four times their normal size. The patient was 32 years old, and had always suffered much at her monthly periods. Her sufferings have gradually increased year after year up to about November last, when she began to manifest symptoms of insanity of a melancholy

religious character, with a suicidal tendency. Her monthly sufferings abated with the advent of the mental infirmity. The patient had been under the care of Dr. M., in Ontario, who suspected some disease of the internal organs of generation, and sent her down to Dr. T. On examination both ovaries were found to be enlarged and tender, the uterus congested, and tender, but otherwise normal. The operation was with the hope of benefiting her mental condition. The wound healed by first intention throughout, and the sutures were removed on the 5th day, not a drop of pus being present. The patient made a rapid recovery, and returned to her home before the end of the third week. But little could be determined as to the result of operation upon her mind, but, so far as could be judged, she seemed somewhat benefited. The future of this patient will be watched with interest and reported to this Society at another time.

Case 2.—Patient, aged 22, has suffered much for several years from pelvic pains, aggravated at each menstrual period. Both ovaries tender and enlarged, uterus congested and very tender, and also retroverted. Attempts at replacement and the use of a pessary had been followed by pelvic cellulitis; even with greatest care could not tolerate a pessary. Rest and local treatment relieved for a time, but when she attempted to work was again laid up. As the girl had no friends or means of support, and her health precluded service, I removed the specimens now before the Society. Both ovaries (as you see) are much enlarged, undergoing cystic changes. The tubes also very much congested. This patient has so far made most unsatisfactory progress towards recovery. There seems to be no healing power in her, and, while no dangerous symptoms threaten life, a tedious convalescence is looked for.

Dr. HY. HOWARD considered the first to be a case of acute dementia, and said that peripheral irritation, especially from the organs of generation, will sometimes be followed by dementia in both sexes, often taking the form of religious dementia. Dr. H. mentioned two or three cases where young men on the first night of their marriage became insane.

Purpura Hemorrhagica.—Dr. KENNEDY mentioned that lately he had under his care four cases of this disease, all in young children of different families. He asked if other members had seen an unusual number of those cases.

Dr. REED said he had been treating one case at the Dispensary.

Nitroglycerine in Epilepsy.—Dr. F. W. CAMPBELL spoke of the continued good results he is having with nitroglycerine in the treatment of epilepsy. None of the patients whom he has so treated have been entirely cured, but with all the attacks are milder and much less frequent. The usual dose which he gives is one drop of a one per cent. solution three times a day.

Dr. TRENHOLME asked for the *modus operandi* of this treatment.

Dr. CAMPBELL said that it was not easy to say how it acted; but if it is true, as some authorities affirm, that with epileptics there is anæmia of the brain from contraction of its arteries, then we can see how the nitroglycerine is useful, knowing, as we do, its action in dilating the blood-vessels of the head, as does smelling nitrite of amyl.

Dr. HY. HOWARD congratulated Dr. Campbell on his success in this treatment of epilepsy, and said that the Germans classified the forms of epilepsy as follows:—1st, Those due to contraction of the cerebral vessels from irritation to the vaso-motor nerves. Here bromide of potassium is very useful. 2nd, An abnormal condition of dura mater. Bromide useless. 3rd, Due to irritation of the anterior pillars of the spinal marrow. Ether spray best for this. 4th, Lesions of different parts of the brain or cord. Of course the difficulty is to be sure of the cause.

Progress of Science.

PROGNOSIS IN HEART-DISEASE—MITRAL INSUFFICIENCY OR REGURGITATION.

An abstract of a lecture delivered before the Harveian Society of London, By W. A. BROADBENT, M.D., F.R.C.P. Lond., and published in the *British Medical Journal*.

The evidence of regurgitation through the mitral orifice is a systolic murmur in the region of the apex, usually heard also to the left of this spot towards the axilla, and often in the left interscapular space, sometimes upwards round the outer side of the mamma. The only murmurs likely to be mistaken for that of mitral regurgitation are a systolic aortic murmur conducted to the apex, a tricuspid regurgitant murmur, and a spurious murmur produced by compression of the edge of the lung. These sources of error being elimina-

ted, a systolic mitral murmur means regurgitation from the ventricle into the auricle.

The causation, however, of mitral incompetence is most varied, and the range of possibilities extreme.

There are, first, the so-called hæmic murmurs of anæmia and chlorosis, of convalescence from acute disease, of some cases of chorea, and of cardiac weakness. It is to these that Dr. McAlister's explanation of mitral reflux, without disease of the valves, applies. The complete closure of the orifice is not effected merely by the floating out of the valvular curtains, but is aided by a great constriction of the orifice, which is part of the ventricular systole. When this is imperfectly performed, the valves do not quite guard the opening, and allow regurgitation.

There is no direct relation between the degree of anæmia and the occurrence of mitral regurgitation; there may be no reflux in the worst cases of anæmia of whatever kind. The state of the blood constituting a predisposition, the immediate cause may be over-exertion, or perhaps climate, or worry. But a direct cause of dilatation of the left ventricle exists in many cases of anæmia, viz., unduly high arterial tension from resistance in the peripheral circulation. This may not only give rise to temporary insufficiency of the mitral valve, but may possibly be the cause of the organic change in it, which Dr. Goodhart has shown to be a probable result of anæmia in many instances.

This "curable mitral regurgitation," borrowing the term from Dr. George Balfour, can usually be recognised by means of the history and condition of the patient, but the character of the murmur may be of assistance; it is usually smooth, accompanies the first sound, instead of extinguishing or replacing, it and not unfrequently it is post-systolic rather than systolic. It is sometimes said that a hæmic mitral murmur is not conducted towards the axilla; but this must not be altogether relied upon.

A temporary mitral regurgitation is not uncommon after acute disease, and may follow acute rheumatism, when it is liable to be taken for the effect of endocarditis.

A mitral systolic murmur during chorea may be either the result of functional derangement or of organic disease of the valves.

In middle age, or in advanced life, mitral regurgitation, without actual change in the valves, is common, and may be induced suddenly by over-strain or illness, or come on insidiously. Sometimes the orifice is of the normal size, at others enlarged; and it is often impossible to say what its exact condition is, or to distinguish between such cases and others in which the valves are damaged. When the orifice is unduly large, there will also be dilatation of the ventricle. The character of the murmur, and especially the presence or absence of the first sound, may be of great service in deciding whether the reflux is considerable or small in amount.

Disease of the valves may be the result either of acute endocarditis, usually rheumatic, or of chronic inflammatory or degenerative change.

The kind and degree of deformity may vary greatly, and we have to endeavor to see our way to the prognosis under these diverse conditions. In some cases, the disease will prove fatal in a few months or years; in others, it may exercise little influence on the health or life. In two instances mentioned, mitral regurgitation had been ascertained to exist twenty years since in patients still living and well; and in another case, repeatedly examined within the last three years, the patient had been condemned to life-long inactivity after acute rheumatism, thirty-five years ago, but was still, at the age of sixty-four or sixty-five, doing strenuous work, a mitral murmur having been known to be present all this time. It is very common to meet with mitral regurgitation at and after the age of seventy, but its duration cannot be ascertained. This form of disease is very frequent among the out-patients of hospitals, and sends into the wards numerous cases of dropsy which recover. It is, in effect, not a deadly kind of valvular affection, and is probably less serious than aortic stenosis, which is placed lowest in the scale of danger. It is not simply that, in a large proportion of cases, the valvular change is comparatively slight; even considerable disease may be long survived, if not progressive.

The first inquiry will be as to the signs and symptoms by means of which the amount of regurgitation may be estimated.

In some cases the character of the murmur affords much information. When it is not conducted much beyond the apex, and is not heard in the back, especially when the first sound of the left ventricle is not lost, but is still audible at the apex, and particularly when the murmur does not begin with the first sound, but follows it at a brief interval, *i.e.*, post-systolic, the leakage is usually inconsiderable. Care must, of course, be taken not to take the soft short murmur of a gaping orifice and a weak heart as an indication of slight mischief, and not to mistake the short sharp first sound of mitral stenosis for a normal left ventricular first sound. Mitral systolic murmurs are often musical, and a musical note would seem to imply a narrow chink and small regurgitant stream; but observation alone must determine the significance of any particular kind of murmur.

For further evidence, the effects of regurgitation through the mitral orifice must be followed. The first of these will be distension, and then dilatation of the left auricle; but, from the deep-lying situation of this chamber, an early stage of enlargement is not easily made out. But the obstruction to the entry of blood into the auricle from the pulmonary veins will give rise to increased pressure in the pulmonary artery, audible evidence of which will be accentuation of the pulmonary second sound. It is not easy, however, to define the degree of intensification of this sound,

which must be accepted as proof of obstruction at the left side of the heart; especially as obstruction may arise in the pulmonary capillaries. From the increase of pressure in the pulmonary artery, another effect follows, hypertrophy and dilatation of the right ventricle, manifested by displacement of the apex to the left, and undue impulse of the right ventricle. But the effects do not end here; the pressure maintained in the left auricle must be such as to afford resistance to the return of blood from the ventricle; and must, therefore, in extreme cases, almost equal the pressure in the aorta. Such pressure must, during the ventricular diastole, drive the blood violently into this cavity, and act as a dilating force, and dilatation will involve hypertrophy. The situation, then, of the apex-beat will be the resultant of hypertrophy and dilatation of two ventricles, and the volume of the heart, as a whole, will be greatly increased.

These changes, the result of mitral incompetence, becomes for us its measure. A systolic mitral murmur, without any of the signs enumerated, and without symptoms, is not attended by much regurgitation, and is not a source of present danger; unless it marks the beginning of progressive mischief, it may be disregarded. As the indications of pressure in the pulmonary artery and of changes in the heart increase, we infer increase in the amount of reflux, and look for diminished stability of the compensation, and expect less power of regaining a working equilibrium if it is once overthrown. These statements are of course subject to the qualifications enumerated in the first lecture.

At the risk of being tedious, one more qualification must be added. It has been pointed out how the right ventricle comes to the aid of the left by maintaining a degree of pressure in the left auricle which resists the reflux through a gaping mitral orifice. The resistance must, when the barrier of the valve is withdrawn, be greater than the pressure in the arterial system. Everything depends, therefore, upon the resistance in the capillaries and the arterioles, and this varies greatly in different conditions. If this be considerable, the arterial tension is high, the backward pressure on the auricle and pulmonary veins is great, and the demand upon the right heart is heavy—all circumstances tending to the production of dilatation and hypertrophy. If, on the other hand, the arterial tension be low, the conditions are reversed. In the case mentioned, of mitral regurgitation known to exist for thirty-five years, the pulse was extremely soft and short; and as there were at one time disquieting symptoms—a sense of constriction of the chest on slight exertion, and a liability to slight fainting attacks—it was feared that the heart was failing. The family pulse, however, is of extremely low tension, and to this the patient owes, in part, at least, his immunity.

The pulse of mitral regurgitation has still to be considered. Its characteristic is irregularity both in rhythm and force, which in advanced cases is

extreme, no two beats being alike. This irregularity, however, is not confined to mitral regurgitation; it is met with in some instances of dilatation of the left ventricle without leakage of the valves, and may be independent of all structural change. Its causation is not very clear, but it is possibly due to the varying respiratory pressure affecting the pulmonary veins and left auricle.

Up to this point it has been assumed that the compensation established has sufficed to neutralise, in a great measure, and under all ordinary circumstances, the effects of the valvular imperfection; but in many instances this is imperfectly accomplished, and the patient is short of breath on comparatively slight exertion, is subject to cough, and presents habitually evidences of venous stasis. The deficient compensation may result either from excessive amount of the regurgitation, or from a failure on the part of the heart to respond to the call for a structural change; and it would be a matter of extreme difficulty to decide between the two on a single examination, especially in the presence of complications, but observation extending over a considerable period, or a full and accurate history, would usually guide to an accurate conclusion. In either case, the leading prognostic indication would usually be the degree of derangement of the circulation and the instability of such compensation as was present.

Even when compensation has been effectual for a time, if any considerable lesion of the valve exist, permitting a serious amount of regurgitation, symptoms will arise sooner or later, either from deterioration of the muscular walls of the heart with advancing years, or from gradual dilatation of the the cavities under the continued strain, or under the influence of anæmia, or as a result of acute disease, especially of the lungs or kidneys; or acute dilatation may be brought about by over-exertion, or excitement, or anxiety. These symptoms are the well known evidences of obstruction in the pulmonary circulation, and of damming back the blood in the systemic veins. The shortness of breath does not require exertion for its production, but comes on in paroxysms without apparent cause, or is habitual, amounting to dyspnoea. The face and lips are dusky, the eyes watery, the hands cold and purple. There is much cough, and the lungs may be congested or œdematous. The urine is scanty, high colored, and loaded with lithates. A further stage of the symptoms is marked by the appearance of dropsy, which may at first be represented by slight œdema of the feet and ankles, which comes and goes, but later ceases to subside, and extends up the legs. As the dropsy advances, the respiratory distress becomes more painful; the patient can no longer lie down, and, in aggravated cases, must sit on a chair or on the edge of a bed, so as to let his legs hang down. Sleep is almost impossible, and the short snatches obtained are disturbed by frightful dreams, and the patient wakes in an agony of dyspnoea and alarm. Unfortunately, the paroxysms are usually worst during the night.

When dropsy is present, or severe pulmonary complications, the prognosis depends mainly on the question whether the symptoms are the direct result of the state of the heart, or have been precipitated by some disturbing influence, such as a chill, or exposure, or fatigue, or anxiety. If no adequate exciting cause can be traced, and due care and caution have been exercised, it is not probable that treatment will reverse the fatal tendency. If the setting in of severe symptoms be explained, then the degree of antecedent dilatation and hypertrophy will furnish us with the important prognostic information already set forth.

As has been said, cases of dropsy from mitral regurgitation very often recover in hospital. The patients, belonging to a class the members of which have to earn their bread, must work hard and undergo exposure, and are frequently subject to hardship and privations. It is under such unfavorable influences that the compensation breaks down, and the reversal of these is often of itself sufficient for recovery. Similar results are furnished by private practice, examples being related.

On the other hand, a gentleman of strong build, who had suffered very little inconvenience from mitral regurgitation, established fourteen years before, but in whom extensive dilatation and hypertrophy indicated considerable reflux, began after a little overwork to suffer from cough and dyspnoea, which was soon followed by œdema of the legs, and the equilibrium thus easily overturned was never regained.

CASE OF VESICO-VAGINAL FISTULA.

By Wm. RALPH BELL, M.D.,

New Edinburgh, Ont.

January, 6th., 1868. Mrs. T——— aged 32 years, consulted me about, as she expressed herself, a weakness of the bladder and inability to retain her urine; in bed or in a reclining posture, it dribbled away as secreted; when up she could retain it about one hour, during warm weather in summer a little longer. She attributes her complaint to her last labour about four years ago. She was attended by a midwife for two days; she would not consent to have a physician called in; at last the woman who was in attendance became so alarmed that she dispatched the husband for the nearest doctor, who on his arrival proceeded to deliver her with forceps. The child was dead; she remained in bed ten days after her delivery, and during that time the urine passed in the natural way. The first time she found the bed wet with her urine was on the twelfth night after her accouchement, and from that time to the present she has suffered from the escape of urine, and has been under treatment almost ever since; states she has tried a number of doctors without receiving any benefit; they all seemed to have looked on case as paralysis of Sphincter Vesicae, caused by the pressure of the child's head or the instruments

used in delivering her. I enquired what the other medical men had done to try and relieve her.

She replied they had given her medicine. Did they examine you? She said only one had made an examination, and that, on close enquiry I found to be only digital. She says they all considered she suffered from paralysis. One doctor galvanized her night and morning for about six weeks, another gave her a prescription for some pills, each pill containing two grains of Quinine and a thirtieth of a grain of Strychnine; such had been the treatment before I saw her. On introducing a common glass vaginal speculum, I found on the left side of the mesial line and about one-inch and-a-half deeper than the orifice of the urethra, a vesico-vaginal fistula was very apparent; the opening was about the size of a five-cent piece; on introducing a silver catheter through the meatus urinarius a small quantity of urine escaped through the catheter and on the contraction of the bladder a little escaped through the fistulous opening; the catheter, could be distinctly seen through the opening. Having determined the extent of the lesion, I felt satisfied that it was a suitable case on which to try the actual cautery, and having fully explained the operation to the patient and pledged her my word that it was not a painful one, she consented, and, being desirous to return home soon as possible, it was decided that it should be done in the morning.

Next morning, at the appointed time, I placed my patient on a table on her hands and knees before a good light, two female friends of the patient being present to assist me.

The vagina being well dilated by a trivalve speculum I had a splendid view of the fistulous opening; having heated a small button-headed cautery to a white heat, I applied it freely to the edges of the opening; she did not complain of any pain during its application. I filled the vagina with a long strip of lint saturated with olive oil; saw my patient comfortably in bed, gave twenty drops of tincture of opium, instructing the nurse to keep her as quiet as possible. On my calling again in the evening found she had enjoyed a nice sleep, was free from pain and in good spirits; emptied the bladder with catheter, ordered twenty drops of tincture of opium at bedtime.

8th. Called early upon my patient; found she had slept well through the night, passed catheter, no urine passed by fistula: evening passed catheter.

9th. Found her up and sitting in an armchair; complains of no pain, no urine passed through fistula, passed catheter and drew off nearly a pint of urine.

10th. Passed urine naturally, renewed the oiled lint.

12th. Was called from home yesterday and did not see my patient till to-day; she had passed urine naturally three times, the oiled lint came away when walking.

16th. She passed urine naturally; stated that on rising this morning she found her bed a little wet; on examination I found the false opening nearly all healed. I informed her I should require to touch the small opening again as it was not perfectly closed, that in the meantime she might go home for a month or five weeks and then return, when I hoped to complete the cure.

March 1st. On examination I found the fistula reduced to about the size that would admit of a small crow-quill being pushed through; on trying I could not pass the point of a No. 7 elastic bougie. Placing her in the same position as before, dilating the vagina with speculum, and having heated to a white heat the stilette wire of a No. 12 elastic catheter, I passed the tip well into the opening, making it touch all round the edges; used no dressing, but desired my patient to frequently micturate, so that the bladder might not become over-distended.

2nd. She has followed my instructions, had no pain; I allowed her to return home, desiring her to let me see her again in a few weeks.

April 17th. Received a letter from my patient informing me she had now perfect control of her urine, none having come away by the fistula; she was delighted to think she was cured; as she was feeling so well she would not visit Ottawa before June, when she would report herself.

June 9th. Mrs. P., called to-day; on examination found the fistula completely closed.—She remarked to me "I have been several times to church recently. I could not go out into public, I had not been to church for nearly four years. I was afraid to go for fear that people would notice the smell."

This case is of some interest. When the fistula is small, I find that they are readily cured by the use of the actual cautery; such has been my experience in several cases. It is better and much easier than to attempt an operation with sutures: again I must remark the operation is almost painless, it is so simple and easily done. If ordinary care is observed, it is also one that wins the life-long gratitude of the patient.

CLINICAL LECTURE ON DISEASES OF THE SKIN.

DELIVERED AT THE NEW YORK HOSPITAL BY L. DUNCAN BULKLEY, M.D.,
Physician to the Out-Patient Department—Class of Venereal and Skin Diseases.

Psoriasis Treated with Chrysophanic Acid.—Eczema Rubrum.—Eczema Rubrum with Varicose Veins.—Recurrent Eczema.—General Diffuse Papular Syphilide.

GENTLEMEN: At the beginning of each lecture we will show the patients, and, if time allows, I wish at the close to spend twenty minutes or half an hour in didactic review of what we have seen. Our clinic depends upon the material sent to us and upon our out-door service here, so that I can-

not always command the cases in the order in which I wish to present the subject. I shall therefore have to take the cases in a desultory manner, and afterward group them together. I will first show you some simple cases before we commence the study of the more obscure ones.

CASE I. PSORIASIS TREATED WITH CHRYSOPHANIC ACID.—This case is very interesting from the fact that, without our intending it, we have had quite a remarkable improvement in the eruption from a treatment which has been advised but which has not been frequently employed—namely, the internal use of copaiba. The patient came here first on account of a gonorrhœa, and not for his psoriasis, which he had had for twelve years, and was put on the treatment for gonorrhœa—on what is known as the Lafayette mixture—a mixture containing an alkali and a little spirits of nitre. When he first came, on April 12th, the psoriasis was in full bloom, very much more marked than now. He was given the mixture of copaiba, but with no local treatment, and as the gonorrhœa diminished his psoriasis greatly improved, so that now his eruption is not of half or quarter its former extent. He says there are no new spots, and, as you see, the eruption is fading. His name is J.B., aged twenty-four. He has had psoriasis for twelve years, with occasional improvement, followed by relapses or increase of the eruption from time to time, it having never entirely left him since its first appearance. What I show you now is not the eruption of psoriasis as you are apt to see it; it has decidedly faded, some of the spots have disappeared, and many are much broken into. On the elbow you will still find the white, slightly adherent, imbricated scales, which very readily come off with light scraping: they are seated on a red base, which, as always, is perfectly distinct and sharply defined, and not with the indefinite outline commonly seen in eczematous patches. On scraping off the scales lightly we soon come to a membranous pellicle, which is adherent, and, if the scraping is carried still further, this comes off and is followed by the appearance of a drop of blood. The eruption, as you see, consists of dusky-red spots, of a size varying from that of a minute pin-head to almost any size, always sharply defined, tending to cover themselves with a white scale, which, on being scraped off, leaves a red base, which bleeds very readily. Remember that the separate spots of psoriasis always appear first as small points, gradually enlarging, and that even when seen as patches of large diameter they have always thus begun; in some localities you may observe the mode of disappearance of the eruption, it gradually fading out, the scales ceasing to form, and finally the redness itself vanishing. We see on the legs very much less eruption than is usually seen on these parts; as a rule, in psoriasis, the legs have more of the eruption proportionately than the body; almost always the patches are larger on the lower extremity, more scaly, and of a darker hue.

Differential Diagnosis—Why do we speak so confidently of its being psoriasis, and state that it is absolutely impossible that it could be anything else? The reasons are found in the character of the lesions, taken in conjunction with the history of the duration of the eruption. There are only four eruptions which could with the slightest reason be supposed to be the one before us; these are: a squamous syphilitic eruption, an eczema, a ringworm, and psoriasis. First, of syphilis: this man has had the eruption for twelve years, with varying severity, and this eliminates syphilis absolutely, as such a general syphilitic eruption never continues that number of years. You may have an ulcerative syphilide for five or more years, but never an acute, distinct from this kind. In the next place, the syphilide would be on the flexor and extensor aspects alike, while in psoriasis the extensor surfaces are always the seat of preference. In the general large papular syphilitic eruption you could never have any such extensive patches of disease as are seen on this man's legs.

Second, in regard to any possible form of eczema which might be mistaken for the present eruption; Eczema seldom, if ever, presents so many separate points of eruption as are seen here; and it may be said that it never exhibits so many of such small size and so sharply defined. Upon some portions of the body psoriasis may resemble eczema, and you see the characteristics it very commonly may take on the lower extremities—namely, the patches are larger, more dusky-red, and of more undefined outline, often more resembling an eczema of the lower extremity. It would be difficult, but not impossible, to make the diagnosis from the eruption on the lip alone.

In certain points this eruption might be thought to resemble ringworm, but yet you would certainly not have such a vast expanse affected with the parasitic disease, and an examination of the scales by the microscope would show the parasite in the latter. The individual spots present differences from those of body ringworm in the pearly character of their scales, the absence of a clearing in the centre, and the rather livid redness of the base of the psoriatic spots. We then make the differential diagnosis from syphilis, eczema, psoriasis, and ringworm; and, recognizing the lesions of psoriasis, we conclude with certainty as to its nature.

This patient continued the use of the balsam of copaiba until the eruption was a good deal faded and broken up, and some weeks ago he was put upon another treatment which has recently been advocated. He has been under the internal use of chrysophanic acid, which has been reported on favorably by several observers, some claiming brilliant results from it. I have several patients under this treatment, but am not ready yet to speak definitely concerning it. He began with a quarter of a grain, in a powder with sugar of milk, taken three times a day directly after eating; and a week ago I doubled the dose. It is best always to begin with a quarter of a grain, and after a few days

give half a grain, and then a grain, until some effect is produced on the stomach or bowels. Some patients are said to have taken up to four or five grains several times daily. When you get to five grains there is sure to be purging and vomiting. He is under this treatment, and has not had any effect from it as yet; but we shall continue it for some time to come, and I propose to push this treatment in as large a number of cases as possible. I wish to give you at the present time the diagnosis and treatment in these cases as we see them, and the theory of treatment I will give you later in the course.

CASE II. ECZEMA RUBRUM.—I bring you this woman to show you a leg which is scaly. It is a case of eczema rubrum of the left leg. She is forty-three years of age, attends to her own household work, being therefore more or less constantly on her feet, and has had an eruption only on this leg. I merely want to show you that, although an eruption is scaly, although it is red, it may not be psoriasis. No case of eczema ever becomes psoriasis. The patient states that she had erysipelas eleven years ago, and that it broke out again two years ago and settled in her back. You will see a great many cases which are called erysipelas, and chronic erysipelas, of the face, etc. We all know there is no chronic erysipelas. It may be chronic by recurrence, but not such an affair as this. This is chronic eczema, which never presents numerous well-defined, sharp patches. See how uneven the edge is, and how it shades off into unhealthy skin; you get a certain amount of erythematous skin, you get it on one half of the body, or, if on the whole body, in continuous patches. This is erythema rubrum, and is one of the cases which, of all others, are perfectly treated with the rubber bandage. I am sorry I cannot put it on to-day, to let you see how to do it. I am afraid this patient does not put it on tight enough. If this leg were exposed to the open air it would crust over, and if closed up at night there would be a surface that would exude moisture. Leave it alone and exposed to the air and that moisture tends to dry. If she had left it alone, untreated, and had scratched it, it would have a large crust; if treated with the rubber bandage there would be no crust upon it, but the scales would come off on removal of the bandage. She states that she left off the bandage for over a year, and that the leg was in as good condition as this until August; but in August, from over-fatigue, she had the eruption develop in spite of the bandage. The tongue is quite indented, and considerably cut; her bowels act every day; her water is very much colored, and stains the vessel considerably. She is taking some medicine, but I do not know what it is. We expected her to say the water was stained. Most of the cases of eczema of the leg are connected with highly colored urine, with a heavy sediment of lime, or some other deposit, from imperfect elimination by the kidneys. It always recurs from over-fatigue or over-exertion.

Differential Diagnosis.—There is nothing like this disease at all, except psoriasis, and that does not come in a profuse form.

With regard to *local treatment*, the bandage is the great thing; it is an invaluable addition, and she would hardly know what to do without it. We shall later on have an opportunity to see it put on and then I will speak of the mode of treatment. For *internal treatment* you generally give diuretics a cathartic, and usually some tonic with all.

I pass to you some plates of eczema, and one of these is a plate of Dr. Fox's, of eczema of one leg, the other leg having a tubing on it. I do not think that is employed now, but that Dr. Fox has himself discarded it. This form of eczema is usually attended with varicose veins, but in this case I find none.

CASE III. ECZEMA RUBRUM, WITH VARICOSE VEINS.—Mrs. Deon, aged fifty-two. She has had a milk-leg—that is, the left leg was affected twenty-two years ago, and again nine years ago. About December 1, 1880, an ulcer made its appearance on the left leg, from which there are large scars, and an eruption shortly appeared after it, and gradually extended up the leg, involving the greater part of the leg when first seen, January 1, 1881. I show you these patients that come back to us, as they are instructive. We get them well to a certain extent; they leave, and there is a relapse. Many of the eruptions have a predisposition to return. She first came to see us January 26, 1881, and was here under treatment for two or three months. She got well under the rubber bandage, then she disappeared, and we did not see her again until September, 1882—a year and a half—which is, of course, a good immunity for a person who is on her feet all the time. The trouble came back in September, and it began on the 22nd, four days before she was seen. Here we have the same lesion as in the former case, accompanied with varicose veins, with very considerable varicosities of the feet. We note here an erythematous condition, which disappears entirely on pressure and readily returns on taking away my hand. You notice the oedema of all the warts. Most cases of eczema of the leg are associated with oedema, which is not necessarily owing to kidney causes. In this instance it is secondary to the milk-leg, or phlegmasia, she had first twelve years ago, and again nine years afterward.

I think, if we want to have our patients remain cured, we must require them to wear the bandage continually, just as persons with certain deformities of the body require the continual use of a bandage or truss; for, as a consequence of leaving off the bandage, we get an affair which seems like a purely local disease, but, in my judgment, is not a local disease. You see some persons with varicose veins who do not have the eruption at all, while others, without having varicose veins, have the eruption. This is, I believe, wholly constitutional. We put her upon the treatment which is commonly pre-

scribed here, and you will hear frequently of it; but I hope you will not consider it routine practice—that is, the diuretic treatment. She is taking the acetate of potassium; it relieves the congestion of the skin, and certainly removes the disease. She is now taking thirty grains three times a day, in a little rhubarb-and-soda mixture, which is mainly used. Locally she has applied an ointment of salicylic acid and balsam of Peru. I merely mention that ointment, but cannot speak further about it now; it is composed of about half a drachm of salicylic acid and a drachm of balsam of Peru to the ounce.

CASE IV. RECURRENT ECZEMA.—I now show you a case of recurring eczema in a child whom I showed you last year—a child who, when you saw her then, had an eczema all over the neck. She remained entirely well until this fall. We saw her here last March, with a history that when six months old she had an eruption lasting until eighteen months ago—I am reading the first record of March, 1881—and this eruption had been on the head for twelve months when we saw her. The head was the seat of a squamous eruption, and all the upper part of the neck, back, and chest was likewise affected with eczema rubrum. There is some moisture there now. She is over four years old, and you see, is an exceedingly small child for her age. When you saw her last year the entire neck was the seat of a moist, exuding eruption. The head was entirely crusted over, and the child was suffering very considerably. There were enlarged glands in the neck, indicating a low vitality and a scrofulous condition. What she shows today is a small amount of scaling, which I wish you to look at closely, I want you also to see this eczema of the eyelids in a child, because such patients are taken to oculists and treated with blue-stone for years, while, if treated for eczema, they would get perfectly well. You see here a swelling of the lids which would not be here if it were not for this eczematous spot, and you find the remains of eczema on the lips. That, of course, may vary to any extent; there may be a thickened eyelid, and when you find it in eczematous subjects you can be pretty sure it cannot be cured without proper constitutional treatment. There is a slightly reddened condition of the eyelids—a puffiness of the whole region of the Meibomian glands. Now, here we still see a certain amount of redness, and a certain amount of erythematous thickening, as the remains of the eczema. I have not seen her for a long time.

Eczema of the eyelids is treated frequently with stimulating solutions—with nitrate of silver, blue-stone, etc., without effect, until the proper treatment for eczema is used. The erythematous condition of the neck is hardly worth seeing. She is better than she was a year or so ago. It is a little over a year since the child had any treatment at all. The scalp was crusted over and the hair matted down, and there was some eruption on the upper lid and on the arms when she came here, Septem-

ber 20th. She was given the syrup of the iodide of iron, a teaspoonful three times a day, and locally she was to use the ointment which you will see continually used, namely, the tar-and-zinc ointment. It is composed of half a drachm of oxide of zinc, two drachms of tar, and six drachms of simple ointment, or rose ointment. That treatment has been continued from the first; she has had nothing but the iodide of iron and the tar-and-zinc ointment. I do not generally use the treatment with the iodide of iron in eczema; that was given in my absence. Although I do not wish to reflect any discredit upon this treatment, yet I do not use it; I do not know why, but I have not been as well satisfied with it as with other treatment. I shall put the child on a little arsenic and ammonia, or the citrate of iron, or the citrate of potassium and sweet wine of iron, made with Malaga wine, under which, I think, such patients improve faster than under the iodides.

CASE V. GENERAL DIFFUSE PAPULAR SYPHILIDE.—I show you quite a different eruption now, gentlemen, in a case of specific disease. I will say, once for all, that I consider it a good deal better to use the term specific disease, and I only use it for one disease—syphilis. Whenever I use the word specific it refers to that, and that alone; it saves me explanation and uncertainty. It is a case of early general diffuse, or general scattered, papular eruption from syphilis. The patient is a widow. She had one child, who died soon after birth. She has had the present eruption for the past three months. When seen a week ago, all the body, face, hands, neck, arms, and legs were covered with the grouped papular syphilitic, and she has mucous patches in the mouth.

I show you the case, gentlemen, for you to compare with the first case I showed you, the case of psoriasis, which in appearance this resembles in a slight degree. Here is a moist eruption which somewhat resembles psoriasis, but the scales of specific disease are always slight as compared with psoriasis. Specific disease does not tend to cover itself with scales, except in the tubercular form. This is a little dark, a little large, and a little too prominent to be confounded with psoriasis. Here is a very interesting point: you find here what is termed psoriasis of the hand, or what is sometimes called psoriasis palmaris syphilitica. Now, in any case of psoriasis you will not find spots like that developed in the palms of the hand. If there is doubt in your mind, *there is a point* which would argue nine out of ten times in favor of its being specific disease. This is a general, large, specific papulide. This woman's primary lesion must have attacked her within six months. There is no eruption on the soles of the feet. There is sometimes seen a little circular grouping of the lesions, but it does not happen to occur in this case; when it does occur it is perfectly pathognomonic. Here is the general large papular syphilitic that might have been covered with more scales, and might in certain other cases represent psoria-

sis. Here is a wax model of the lesion; they call it *syphilide palmaire*, but there is no propriety in calling it that. Now, you notice I have made this diagnosis without a word from her. I do not care whether she had the primary lesion or not; there are characteristics which are absolutely positive. You will see the spots are solid, and are erythematous, and disappear on pressure; they are not stains; they may be acute and new, and there are also some stains left from the former lesion. There is some little analgesia, or loss of sensitiveness to pain, during the early acutely developed phases of syphilis. It is more common in women than in men. I have patients on this platform into whom I could stick a pin without their knowing it. There is entire loss of sensitiveness. We have here a general diffuse papular syphilide on the face, as well as on the body, and I should suspect the face if there were none on the hands. There are features here which might be mistaken for those of acne, and might be something else; but one point would lead us to diagnosticate syphilis, and that is the scattered appearance which the lesions present—I mean covering the whole face. You see an acne group, but never see an acne on the lip in that way.

She is under the "mixed treatment." I believe in giving her a slight amount of hydrargyrum early in the disease, and I believe occasionally a little iodide added to it will help the disappearance of the eruption. She is taking a mixture with a little iodide in it, because it does hasten it, in my judgment. She has been under the treatment only a week or ten days, and the eruption is getting somewhat less than it was.

ON THE TREATMENT OF CARBUNCLE BY COMPRESSION.

Discussed in the Hospital of the University of Pennsylvania,

By JOHN ASHKURST, Jr., M.D.,

Professor of Clinical Surgery.

Reported by LOUIS J. LAUTENBACH, M. D.

This man has been already before some of my ward classes; but, as there are many present today who do not meet me in the wards, I am glad to have the opportunity of bringing him before you. He presents one of the most instructive cases which we have had in the hospital this winter.

This patient was admitted to the ward on Wednesday of last week, being ten days ago, with a very large carbuncle of three weeks' duration. It began as a pimple, and gradually increased in size. This is the usual history of a carbuncle: first, the presence of a pimple, which soon develops a central vesicle, and then, either with or without irritation, such as scratching or pricking with a pin, begins to spread, the carbuncle in a week or ten days attaining its maximum size, seldom more than four or five inches in diameter. Yesterday a week ago, measuring

this carbuncle we found its dimensions to be nine inches by eight, independently of the large amount of indurated tissue around the livid mass itself. The dimensions of the carbuncle, including this indurated tissue, were at least eleven by ten inches, and it was fully three inches in depth.

A carbuncle is in reality nothing but a large boil: there is no absolute distinction between a furuncle and a carbuncle. This carbuncle is now smaller than it was when the patient came to the hospital, and it is subsiding every day, though up to the time of the patient's admission it had been steadily increasing in size.

There are some peculiarities about the ulceration of a carbuncle which have not been understood until quite recently. It had long been observed that carbuncles were apt to ulcerate at numerous distinct points, giving the surface a sieve-like or cribriform appearance; but the anatomical explanation of this condition has only been furnished within a few years by an American surgeon, Dr. Collins Warren, of Boston. By microscopical examination of the skin of the back, where carbuncles usually occur, Dr. Warren has found little processes or tubes of fat connecting the deeper tissues with the surface; he has named these tubes the fatty columns, or *columnæ adiposæ*; and it is along these columns that the pus of the carbuncle, which originates as a phlegmon of the deep cellular tissue, begins to make its way to the surface. In this case there are as yet but two openings, which lie close together and probably will soon coalesce. A slough—what is popularly called the *core*—is beginning to protrude from one of these openings: it is a slough of the deep cellular tissue.

Carbuncle, while a very painful and annoying affection, is usually not a very dangerous one when properly treated. Death does, however, occasionally follow, and I have recently seen the statistics published by a German surgeon, who treated eleven cases of carbuncle by incision, six of these proving fatal by pyæmia. I have myself seen no death from carbuncle, nor do I recall any in the practice of other surgeons, unless in cases where there was some grave constitutional complication.

Carbuncle in one part of the body, the face, is considered particularly dangerous. It is said that but one case in nine gets well; but my own observation would lead me to think this an exaggerated estimate. This is a comparatively rare form of the disease, but I have seen two or three cases of facial carbuncle, all of which have ended favorably; it is true, however, that none of them were very severe. Death in facial carbuncle results from transference of the inflammation to the sinuses of the dura-mater, or from pyæmia. But in ordinary carbuncle, unless the patient has Bright's disease, or diabetes (an affection which predisposes to carbuncle), or unless the inflamed mass is so situated as to endanger internal organs,—peritonitis may follow abdominal carbuncle,—death will

seldom ensue, except as a result of injudicious treatment.

The old-fashioned treatment, which in my student-days we were taught should be used in every case, was to make an incision the entire length and depth of the carbuncle, this incision being crossed by another at right angles to it, and extending the entire breadth and depth. Had this mode of treatment been practised in the case before you, we should have had two incisions, one eleven inches long by three deep, and the other of the same depth and ten inches in length. You can see what an enormous wound would have been made, and how much blood would have necessarily been lost. Death even may occur from hemorrhage, for there is a recorded case in which a surgeon made the regulation incisions in the afternoon and directed the nurse to apply a poultice, saying that he would see the patient in the morning. Next morning he went to see his patient, and found that he had died from hemorrhage during the night. Then, besides this risk from bleeding, incisions increase the risk of absorption of poisonous matter, as they leave a very large raw surface. Another, though less serious, objection is that the resulting wound is a very large one, and that the time required for healing is correspondingly prolonged. In order to avoid hemorrhage, some surgeons practice subcutaneous incision; but this is an uncertain operation and presents no particular advantage.

Of course, the treatment by incision has something to be said in its favor. No course of treatment could have been in general use for so many years without being of some value. It somewhat diminishes the pain of the carbuncle, and sometimes seems to prevent its spread, but it is not always certain even that it will do this. The disadvantages of incision I consider much greater than its advantages.

There is another mode of treatment which is adopted either by itself or in connection with incision,—the use of caustics. They are either employed to cause central sloughing, or are applied as "caustic arrows," like the spokes of a wheel. The use of caustics in this way was introduced by Maisonneuve for the removal of tumors, and Sir James Simpson recommended the injection of caustic solutions in a similar radiating manner. I can remember quite distinctly the case of an old man with carbuncle who was a patient in the Pennsylvania Hospital when I was a resident physician there. The usual crucial incisions had been made, causing great pain and free bleeding, and it was my duty every day to cauterize the wound with the solid stick of nitrate of silver; and I can remember how that old man used to fairly shiver with the pain at every dressing. He got well at last, but it was after many weeks of needless suffering.

The first case in which I used the pressure treatment, which I now invariably employ, was that of an old woman at the Episcopal Hospital,

who had a large carbuncle, and who was so old and feeble that I thought it would be really dangerous to make incisions. Mr. O'Ferrall, an Irish surgeon, was the first to recommend this mode of treatment: he applied compression by means of a plaster made to cover the whole mass of the carbuncle, and when suppuration began he cut a central opening for the escape of pus. I have preferred to use adhesive strips laid on concentrically, just as we use them in the treatment of swelled testicle.

We begin to apply the strips at the margin, and gradually bring them more and more inward, leaving a space at the centre to allow the slough to come out. We began treatment in this case last Wednesday week: up to that time the carbuncle had been constantly increasing, but since then the progress, fortunately, has been the other way. The pain was immediately much relieved, so that the patient has now only an occasional darting pain, but nothing really to give him distress. The carbuncle is smaller, and is getting flatter. It now measures eight by seven and a half inches, and is not more than two and a half inches deep. The patient has not lost a drachm of blood since he came into the hospital. You can see that the pus and sloughs of cellular tissue are slowly discharging themselves, and there is so far no sign of any additional opening. We have every reason for thinking that this patient will convalesce without any further trouble. Over the centre of the carbuncle we are using a small poultice, which we will change after a time for a dressing of resin cerate or zinc ointment, as may seem desirable.

There is another mode of treatment of which I have heard, but which I am happy to say I have never seen practised. Some surgeons have been so heroic as to excise the whole mass of the carbuncle; some surgeons, too, have excised gummatous tumors. The first can be made to disappear by simple compression, and the second will be absorbed under the use of iodide of potassium. To excise the one is as unjustifiable and as unnecessary as to excise the other.

In this case, on account of the mode of treatment which we have adopted, the ulcer left after the separation of the sloughs will be small, and the cure will be much more rapid than it would be if we had made incisions. I do not know of any instance in which the dicta of "authority" have come down to us with more injury than in the treatment of carbuncle by incision.—*Philadelphia Medical Times*.

A CASE OF TRUE CROUP TREATED BY LARGE DOSES OF MERCURY.

By O. T. SCHULTZ, M.D.

The systematic use of mercury in pseudo-membranous inflammation of the upper air-passages—diphtheria and true croup—dates back to the eighteenth century, and seems to have originated

with American practitioners. I am not able to state in what particular manner mercury was first used by the originators of the treatment, what results they attained, and what evil effects, if any, accompanied its methodical employment. The practice seems to have extended rapidly, as every method of treatment for which good results are claimed in severe affections has always done, and very soon we find the leading clinicians of America, England, Germany, and France lauding it highly.

Two methods of using mercury seem to have been in vogue up to the middle of the present century. In the first it was employed early in the disease, either in small, oft-repeated doses, or in a few large doses, in conjunction with mercurial inunction. In the second it was given later in the disease when either its severity had been broken by antimonials, or after all other means had failed. None, however, of the many and illustrious practitioners who recommended mercury in pseudo-membranous inflammation of the upper respiratory tract had pinned their faith solely to either method, but, regarding mercury simply as an efficient auxiliary, had used it in conjunction with such other means as were in vogue at the time; that is, they had bled and blistered and cauterized and vomited and steamed and cut until their patients were no more, much in the same fashion as patients of the present day do under our own blind though well-meaning hands.

A reaction now set in against the mercury treatment, and authors became either silent or expressed their doubts of the usefulness of mercury in true croup and diphtheria, or positively warned against its employment, deprecating with Steiner the exhaustion accompanying the continued use of the drug, or maintaining with Mackenzie "that experience has long since taught us that the general influence of mercury on the system rather promotes than checks the spread of the exudation."

Still, even during this period of reaction against mercury, many men of large experience had stood up for the beneficial results to be derived from its use, restricting it, however, like Jacobi, to sthenic cases, with a fibrinous deposit, in which the disease remains local, and does not give rise to constitutional symptoms, and absolutely condemning its use in æsthenic cases that tend to assume the septic or gangrenous form. These upholders of mercury recommended the administration of *fractional* doses of calomel, often repeated, according to the plan of Albeos (one-fourth to one-half grain every hour until twenty to thirty grains have been given), the practice of exhibiting *large* doses having fallen entirely into disuse.

Within the last five or six years the mercurial method has entered upon another phase—that of a specific for the germs claimed to lie at the bottom of the pseudo-membranous process—and current literature is replete with reports

of cures obtained by the cyanide, the red or yellow iodide, the bichloride, and the mild chloride of mercury. And since within the last year or two the king of germ-destroyers has again been found, and found in *mercury*, we will soon have drifted out of carbolomania into a furor hydrargyricus, and we may soon expect to see the specificity of mercury in this form of inflammation proclaimed as an axiom in therapeutics *ex omnibus cathedris*.

But while the great bulk of practitioners employing mercury in this affection at the present time are doing so on account of its germicidal properties, a very zealous and enthusiastic apostle of the practice has arisen in the person of Dr. W. C. Reiter, a physician of high standing in Pittsburgh, Pennsylvania, who attempts to explain the brilliant results he has attained in quite a different manner. Dr. Reiter also believes in the specificity of mercury in pseudo-membranous inflammation of the upper air-passages; but while the believer in germs attributes the disease to a *contagium virum*, for the destruction of which mercury is the specific, Dr. Reiter holds that this inflammation is due to "too much fibrine in the blood," which condition is produced by the liver having lost its fibrine-destroying power, and that mercury is the specific for compelling the liver to resume its function. Be his theory right or wrong, Dr. Reiter has put it into practice with great boldness, and with astonishing results. And he anchors his faith fully and squarely upon mercury in all forms of pseudo-membranous inflammation—fibrinous, septic, gangrenous and sthenic—without ever engaging in those delicate subterfuges, steaming, burning, or cutting. His results are reported to be marvellous, and unattended with any unpleasant after-effects, while the boldness with which he pushes mercury makes one's hair stand on end. He administers, after an initiatory dose of twenty grains of calomel, ten grains of this mercurial every hour, with potass. chlorat., five grains, every three hours, for twenty-four or forty hours, or until improvement sets in, and then continues it in smaller doses at longer intervals until the disease is cured. Reiter and his followers think nothing of giving half an ounce, an ounce, or more of calomel to cases of diphtheria or croup, and claim to have witnessed no bad effects, but to have cured the most desperate cases!

NITROGLYCERINE AND THE CHLORIDE OF GOLD AND SODIUM IN THE TREATMENT OF ALBUMINURIA.

By Dr. Roberts Bartholow (*Med. Jour.*)—Chloride of gold and sodium have long been known to have a special direction to the genito-urinary apparatus. The ovarian and uterine organs in the female, the testes and vesiculae seminales in the male, are stimulated by it, and the kidneys, by means of which it is eliminated, and in which it tends to accumulate, are decidedly affected by it in

function and structure. In common with some other agents of the class to which the gold belongs—for example, corrosive sublimate—the chloride acts on connective tissue and checks its over-production, or its hyperplasia. It would be quite impossible in this note to go over the evidence on these points, and hence I must ask your assent to these statements. They have been accepted as true of gold, from the days of the alchemists, and iatro-chemists, as any one may ascertain from that curious collection of mediæval medical learning—the Anatomy of Melancholy. It has happened, strangely enough, that Hahnemann and his followers have profited by this knowledge, and have used gold preparations—especially *aurum potabile*—in the treatment of renal diseases, with success.

How and when are these remedies to be used?

Nitroglycerine is now administered, as all present know, in the form of the centesimal solution—1 minim of the pure drug to 100 minims of alcohol. The initial dose of this one per cent. solution is one minim, which should be increased until the very characteristic physiological effects are produced. The susceptibility to the action of nitroglycerine varies greatly, and hence the dose cannot be stated in advance. It is necessary to produce some obvious effect. To maintain the same level of action, a slight increase in the dose may be required from time to time. As the effect is not lasting, the interval between the doses should not exceed three or four hours.

The administration of nitroglycerine should begin in acute cases immediately after the subsidence of acute symptoms. It is indicated in chronic cases at all periods, but is more especially useful, if given before hypertrophy of the muscular layer of the arterioles has taken place. When it acts favorably, the amount of albumen in the urine steadily diminishes. The mechanism of its action consists in the lowering of the pressure in the renal vessels. How far any curative effect proceeds from action of this remedy on the sympathetic system, remains to be determined.

Chloride of gold and sodium is indicated in the subacute and chronic cases, especially the latter. The earlier it is given the better, if structural changes are to be prevented or arrested. The good effects to be expected from it will depend necessarily on the extent of the damage already inflicted on the kidneys.

The usual dose is $\frac{1}{20}$ grain, twice a day, but this may be much increased if necessary. At the outset, $\frac{1}{10}$ grain may be given; in a week the dose should be lowered to $\frac{1}{15}$ grain, and after a month the regular dose of $\frac{1}{20}$ grain should be steadily pursued, with occasional intermissions. Indigestion, gastralgia and colic pains, nausea or diarrhoea, are occasionally caused by it; and, if so, the quantity administered must be reduced. It is usually borne without any discomfort; but, after prolonged administration, salivation, weakness, emaciation, trembling and other nervous phenomena may occur possibly. Such effects, however, are wanting in my experience.

The treatment of albuminuria by nitroglycerine and the chloride of gold and sodium does not necessitate the exclusion of other means—hygienic climatic, or dietetic. These remedies should, however, be given uncombined, at different hours, and their action should not be hindered or obscured by the effects of other agents given with like purpose. To this general statement there may be two exceptions: with nitroglycerine, amyl nitrite or sodium nitrite may be given; with the gold and sodium chloride, corrosive sublimate may be combined. If doubts may be felt in regard to the propriety of depending on the utility of these remedies, they need not be long experienced, for, if no good effects are observed in two weeks, they may then be discontinued.—*American Med. Digest.*

LESSONS FROM THE OBSTETRICAL DEPARTMENT OF THE PHILADELPHIA HOSPITAL.

Dr. Theophilus Parvin in the report of his quarter's service (read before the Philadelphia County Medical Society), details well some important observations, and supplements the same with useful deductions. The following three facts induce him to discuss at length the third stage of labor:

One of the colored women failing to expel the placenta within an hour after the birth of her child, the gentleman having charge of the case introduced his hand into the uterus and removed the after-birth by piecemeal, or at least the greater portion of it. That patient had septicæmia, and infected each of her neighbors; the colored obstetric ward at this time was terribly crowded, the beds so close together that a patient could almost roll from her own bed into the next one.

Shortly after this I was called to a woman in one of the white obstetric wards, who had been delivered of her child three hours before, but the placenta was retained. The patient's pulse was good; there was no hemorrhage, nothing but the simple fact of delay in the third stage of labor. A little friction of the uterus, and compression of its fundus through the abdominal wall, caused the expulsion of the placenta in a few minutes. There was no fragment of the after-birth or of the membranes retained; the genital organs of the patient were not touched either by the interne or by myself in this delivery, nevertheless she had septicæmia. Finally, a third patient had the placenta retained for nearly five hours, and then it was expelled. She had septicæmia. These three patients recovered.

Dr. P. then discusses at length the doctrine of retained placenta as practised by various obstetricians, and expresses his own opinion as follows:

As long as the placenta is wholly attached, hemorrhage is impossible; the placenta is still a living structure, and one with the uterus; to tear it loose, to directly detach it from the uterus, opens the way for perilous hemorrhage. Not only this,

but such artificial detachment is usually incomplete, is liable to injure the uterine tissue, and the operator's hand may be the bearer of septic germs, or these may pass in with the air admitted during the manipulation, and find a congenial soil for their development in fragments of placenta, or blood-clots that are retained in the uterus. Therefore, unless hemorrhage demands immediate interference, the obstetrician refrains from passing his hand into the uterine cavity for the removal of an attached placenta; a completely adherent placenta is not so dangerous as the intra-uterine use of the hand for its detachment. I believe, then, that armed expectation is wise in the latter case, only endeavoring, by suitable compression of the uterus with the hand actually through the abdominal wall, to determine or assist that retraction of the organ which is nature's method of separating the placenta. After the detachment of the placenta—a fact which is best learned by feeling part of the organ with the finger passed into the mouth of the womb—we may, by friction and compression of the uterus, if needed, evoke uterine contractions which will cause its expulsion. Those who believe that the placenta presents its foetal surface at the os uteri, urge the value of moderate and continuous traction upon the cord, thus assisting the moulding of the mass to the orifice through which it is to come. This conservative view as to the management of so-called retained placenta has been strongly presented by Siredey in his recent work upon puerperal diseases. The common expression, retention of the placenta, means very different conditions, each requiring its appropriate treatment.

Dr. Parvin's report contains another important lesson on septicæmia and its temperature and the difficulty of diagnosing a case of septicæmia from malarial infection, and concludes with a brief study of a ruptured uterus.

The uterus was ruptured in consequence of a shoulder presentation, a case which ended in death the eighth day after delivery. Yet I would fail in duty to my profession that has been so good, so generous to me, if I did not make the case fully known. The patient was a well-formed healthy multipara; she had been in labor nearly twelve hours when I first saw her, the left shoulder presenting. Ether was immediately given until she was thoroughly under its anæsthetic effect; and then, without violence, nay, with great ease, I passed two fingers behind the right knee, brought the foot down, and turning and delivery were effected in a few minutes; the placenta followed almost immediately; the child, quite a large one, was dead. The patient came out from the anæsthesia satisfactorily; her pulse was good; there was no complaint, no shock, no great hemorrhage. Yet that woman had a ruptured womb, the tear beginning at the os uteri on the right side, involving the cervix and the lower part of the body of the uterus, this condition being made known by the post-mortem. If it be thought I ought to have

known this accident at the time of delivery, I can only say that like ignorance happened to Dubois, to Hervieux, to Tarnier, and others—the first revelation of the uterine rent being made at the post-mortem; these silent tears of the womb are, as Hervieux has suggested, probably more frequent than generally thought. No, my self-reproach is not in this, but in not having made myself, or by another, an examination during pregnancy, so that the abnormal presentation could have been corrected, if not then, at least early in labor. But let this pass. The great practical lesson to be drawn from the accident is not only the importance of an early rectification of a malpresentation, but also an appreciation of the danger of rupture of the uterus and how this accident occurs. The drawing now shown gives the position occupied by the child, and also and especially gives the change in form and thickness of the two cavities of the uterus, which, as so admirably described by Bandl, are formed when nature is unable to overcome the obstacle to labor found in such case. The one cavity is formed by the body of the uterus, and its walls become thicker and stronger; the other, by the cervix, and its walls grow thinner—become indeed so attenuated and weak that a very slight additional strain at some point; that strain may come from a uterine contraction, or solely from the introduction of the finger; and thus peril from action, peril from delay must be before the obstetrician's mind when called to a case of neglected shoulder presentation.

Of course had I seen this patient an hour or two earlier, the event might have been different. The pressure of the presenting part had been so severe that a slough of the vesico-vaginal wall occurred, and the patient, had she had recovered, would have required an operation for the resulting urinary fistula; I have thought that possibly the uterine rent was in part the result of a slough also; but be this as it may, there was not the slightest indication given at the post-mortem that any hemorrhage in the abdominal cavity had taken place.—*Chicago Medical Press.*

TREATMENT OF ECZEMA OF THE GENITALIA; AND LEUCORRHEA.

In cases of eczema, in which glyceroles and unguents have failed, the following formula has been successful:

Chlorate of potassium.....30 grains;
Wine of opium.....50 grains;
Pure water.....1 quart.

Applied to the parts by linen compresses covered with oiled silk. If there is much inflammation, precede this with warm hip-baths and cataplasms sprinkled with powdered carbonate of lime. In obstinate pruritus, associated with leucorrhœa, a tablespoonful of a mixture of equal parts of tincture of iodine and iodide of potassium; in a quart of warm tar-water (tar-water holding the iodine in

-solution), used daily, night and morning, removes the pruritus and ameliorates the leucorrhœa. In fetid leucorrhœa, two or three tablespoonfuls (in a quart of warm water, morning and evening, as an injection) of the following formula will be found useful :

Chlorate of potassium,.....13 parts ;
Wine of opium10 parts ;
Tar-water,.....300 parts.

Or,

White vinegar (or wine).....300 parts ;
Tinct. eucalyptus,..... 45 parts ;
Acid. salicylic,..... 1 part ;
Salicylate of Sodium,..... 20 parts.

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

TINCTURE OF GUAIAIC IN ACUTE SORE THROAT.

Various medical authorities have borne more or less emphatic testimony to the value of tincture of guaiac in sore throat.

Stillé, in his *Materia Medica* says, "Guaiac has been recommended in tonsillitis by Dr. Hanney of Glasgow, Mr. Bell, Dr. Carson, and Mr. Carter. According to their statements, it abates pain and inflammation with singular rapidity and uniformity. He does not seem to have had any personal experience with the drug in this disease.

In his *Practice of Medicine* Dr. Fred. T. Roberts states that guaiacum has been supposed to exert a special influence upon the disease in question.

Phillips, in his *Materia Medica and Therapeutics* indorses the use of the drug in the following terms : "Recent clinical experience has shown that guaiac is a capital remedy in tonsillitis. Given in half-drachm doses (tincture) every four hours, it appears to abate the inflammation, and to cut short the disease in a remarkable manner."

Mackenzie, in his work on *Diseases of the Throat*, says, "In cases of deep tonsillitis..... fortunately there is a remedy, which, if administered at the onset of the attack, will almost always cut short the crescent inflammation. This is guaiacum."

Dr. J. B. Potsdamer, in a paper read before the Philadelphia Laryngological Society, and printed in the *Medical and Surgical Reporter*, after referring to the above and other authorities, remarks :

I was first led to use this treatment in the winter of 1879, and then only after a succession of trials upon myself. During that winter I was subject to attacks of sore throat. The first, which occurred in November of that year, was quite severe, and was entirely cured in two days. About six weeks later, after exposure to wet and cold, was threat-

ened with another attack, having sharp pains in the region of the tonsils, and difficulty in swallowing. The parts were highly congested. This attack was aborted by the prompt use of the ammoniated tincture of guaiac in half-drachm doses every three hours. Was well in twenty-four hours. Two subsequent attacks were aborted in like manner. Since then have not had a recurrence.

A detailed report is added of a number of cases which show the efficacy of guaiacum, not only in ameliorating the symptoms, but also in cutting short the disease.

SORE THROAT IN CHILDREN.

Henry Ashby, M.D., M.R.C.P., (*Practitioner, London, Dec.*) mentions four principal varieties :

1. Simple tonsillitis. 2. Scarlatinal tonsillitis.
3. Pseudo-diphtheritic. 4. Diphtheria.

Weakly and scrofulous children are especially subject to the first. It is oftener seen as a complication of alimentary disorders, as those of liver and stomach, than of the respiratory tract, as bronchitis and laryngitis. It frequently precedes rheumatic attacks. It may be the result of the scarlatinal poison. In proof of this, he cites an interesting series of eight cases occurring in a hospital ward within a few days. Several nurses also took the disease. The first patient attacked, it was found, had been exposed to genuine scarlatina a few days before. None of the cases had an eruption. One a patient in previously bad condition, died. No insanitary conditions prevailed.

In view of the difficulty—at times the impossibility—of diagnosing scarlet fever from simple tonsillitis, the writer recommends the isolation of all children with febrile sore throat as long as faucial congestion remains. The points in favor of scarlatina are: the presence of vomiting and diarrhœa in the stage of invasion; a pulse of 130-160; not necessarily a high temperature; marked injection of the uvula pillars of the fauces and tonsils. Later the enlargement of the cervical lymphatics with tenderness; the implication of the nasal mucous membrane, and a yellow exudation over the tonsils and uvula, make the diagnosis of scarlatina tolerably certain.

Under pseudo-diphtheria the writer includes a class of cases which are said to bear the same relation to diphtheria that epidemic tonsillitis bears to scarlatina. It prevails where diphtheria does, is attributed to sewer-gas and other poison. They differ from it in that the cervical glands are rarely involved, the membrane is less tough, the nasal mucous membrane unaffected, the urine does not contain albumen. The usual sequelæ of diphtheria are absent. The prognosis is always good. The duration is rarely over a week.

The sore throat of diphtheria is differentiated from anginose scarlatina, by the fact that in the latter we rarely have true membrane. A yellowish exudation may cover the tonsils, perforation and even sloughing of the palate may occur, and there may be much external cellulitis, but the leathery, whitish, adherent exudation of diphtheria is absent. The amount of albumen in the urine of scarlet fever is usually slight; in diphtheria it is often fifty per cent.—*Archives of Pediatrics*.

TO ABORT A STYE.

Dr. Fitzpatrick, in the *Lancet*, says he has never seen a single instance in which the stye continued to develop after the following treatment had been used: The lids should be held apart by the thumb and index finger, while the tincture of iodine is painted over the inflamed papilla. The lids should not be allowed to come in contact until the part touched is dry. A few such applications in the twenty-four hours are sufficient.

THE TREATMENT OF PELVIC CELLULITIS FOLLOWING PARTURITION.

Dr. W. M. Graily Hewitt thus concludes an article in the *Medical Press*, November 21, 1883:

A few words with respect to the treatment: A remarkable feature in these cases is their tendency to chronicity. They are always tedious and difficult to cure, and the cure depends more on attention to diet than on any other element of the treatment. Rest, of course, is an essential; but the nutrition requires careful consideration. With regard to the subject of food: Deficiency of food may predispose to cellulitis in a patient in whom other factors in its cause may be present: or it may render an already existing case of cellulitis less amenable to treatment. In the case before us the quantity of food taken was perhaps only one-third of the total amount required by the healthy subject. This created a weakness which showed itself in various ways. Under these circumstances there is a great indisposition to take food, and if only three stated meals a day are provided, a very small amount is taken; the patient becomes exhausted in the intervals, and when meal-time comes is not able to take nourishment. Hence the quantity taken is not enough to induce activity in the nutrition process, but only enough to keep up a condition of *statu quo*. To stimulate nutrition, articles capable of ready assimilation must be selected—Brand's essence, beef tea, milk, etc., with a fair amount of stimulant in the shape of brandy, and this must be given very frequently, every hour or so. Under this treatment the appetite will rapidly improve, and in a week or so, in all probability, solid food will be taken with zest.

As subsidiary treatment, poultices may be applied to the abdomen to relieve pain and assist resolution, and if the latter is very severe a little opium is indicated. The bowels should be daily opened by the administration of a mild laxative. Some medicine, in the shape of dilute nitro-muriatic acid, with a little tincture of orange, is often useful as a stomachic and tonic; and later on iron and quinine may be given with advantage.—*Med. and Surg. Jour.*

IODIFORM SUPPOSITORIES FOR PILES.

The following recipe for suppositories for hemorrhoids is from the *Zeitschrift für Therapie*:

℞ Iodoform.....	4 parts
Balsam Peru.....	8 "
Cacao butter	} of each.... 6 "
White wax	
Calcined magnesia	4 "

Mix. To make twelve suppositories. One to be introduced after stool each time.—*Druggists' Circular*.

TREATMENT OF URTICARIA.

Dr. McCall Anderson publishes a lecture on this subject (*Br. Med. Journ.*), from which we deduce the following on treatment: First, find out and remove the cause. In acute cases a sharp purge is useful, especially if there be indigestion. If indigestible food is still in the stomach give an emetic. Avoid stimulating diet. In chronic cases by varying the diet we may trace the offending article of food—malt liquor, spirit, white wine, vinegar, fruit, sugar, fish, vegetables, etc. In some cases complete change in diet is not of the slightest avail. When no cause is apparent, or the disease continuing after its removal, we must treat empirically. Most is, perhaps, to be expected here from atropia ($\frac{1}{16}$ grain subcutaneously at night or night and morning), and bromide of potash (gr. x three times a day). Continue till physiological effects are apparent. Occasionally a continuous current twice a day is useful, the positive pole being placed at the top, the negative at the bottom of the spine. We may also try sulphuric ether, 20-40 drop doses, or quinine in full doses, or arsenic. Complete change of air, scene and occupation, may become necessary, and a visit to Vichy is sometimes advantageous. Relief is obtained by sponging with vinegar and water, Cologne, or ℞. *Acidi carbonici cyst.* 3 ij; *glycerini* (Price) 3 vj; *eau de Cologne* 3 j; *aquæ destillatæ* ʒ iv, or ℞. *Chloralis hydratis, camphoræ* aa ʒ ss; *miscæ et adde glycerini* (Price) 3 j, *unguenti simplicis ad* ʒ j, or tarry preparations, as a lotion of equal parts of tar, soft soap and rectified spirit; the last may exceptionally yield permanent benefit.

THE CANADA MEDICAL RECORD

A Monthly Journal of Medicine and Surgery.

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MONTREAL, JUNE, 1884.

TO OUR READERS.

We have to apologize to our readers for our very tardy appearance of late. The chief cause of this has been the removal of our printers into a building in rear of the one they previously occupied. The old one is being torn down and will be replaced at once by a large and beautiful building which our publishers hope to enter by the end of the year. We will soon make up leeway, and hope to be more regular in future.

The Committee to select a site for an Asylum for the Protestant Insane have been running round the Province in search of a location.

It is a question whether they know *what* they want, as grounds varying in size from a 15-acre lot upward have been inspected.

To our mind their duty is clear: Estimate the probable number of male inmates, look to the probable increase in the future, and at least an acre for each male patient must be the minimum quantity of land secured. It is wasting time to travel about the country looking at locations that cannot begin to give this *necessity*. Moreover it opens up the question whether the committee is fit for its duty.

At the quarterly meeting of the Governors of the Montreal General Hospital, to be held on the 13th of August, the proposed change in the by-laws, viz: to name a Gynecologist and a Laryngologist to the Institution, will come up for ratification. Although, from what we hear, there

may be some objection to the by-law, yet it will beyond doubt be carried.

It is a question whether, when the by-law has been passed, it will be wise to proceed, after ten days, as we believe may be done, to make the appointments.

Who will receive these appointments is of course a foregone conclusion. Two gentlemen on the out-door staff will be thus promoted. Their election will not cause competition, but for the two vacancies thus to be created, there are several candidates. If the election takes place, as permitted by law, it may place some of these gentlemen at a great disadvantage. Many of the Governors of the Hospital will at that time be out of the city, while many others will be deeply engaged in preparing for the meeting of the British Association for the Advancement of Science.

There is no reasonable excuse for hurrying these appointments. The November meeting of the Governors will soon come round. Then our city will have recovered from the excitement of the great scientific meeting, and those in whose hands these appointments lie will have time to consider the claims of the various candidates. We have heard this view expressed by many interested in the Hospital, and we trust that those who have been the prime movers in suggesting these additions to the staff, will show their good sense by not pressing an immediate election.

While upon the subject of the Montreal General Hospital it may not be amiss to say that those who for years have been able to carry their nominee at all elections, at this moment occupy a very delicate position. The last election developed an opposition which they little thought to exist in the strength which it then exhibited. That opposition is a powerful and a wealthy one; it has contributed handsomely to the support of the Hospital in the past. If it is to continue to do so in the future will largely depend upon the action of the party hitherto in power. Financially the Hospital is in a critical position; it needs the support of ALL. If they act wisely this support can be assured. If they

act so as to show a determined hostility to this large body of Governors, much of this support will be withdrawn. We know that our assertion is true; we point to the subscription list of the Hospital for the last year, to show that this withdrawal of support has *already* commenced. Unless wise counsel prevail this will continue and largely increase. The Hospital cannot afford to allow the private interests of a few to alienate from it any large amount of public support. Let the medical men who have wielded this power learn the lesson in time.

This warning is necessary. Although not generally known, an attempt has been made by a portion of the Medical Staff of the Hospital, to so arrange the vacancies which will be created by the appointment of a Gynecologist and a Laryngologist, as to operate against one of the candidates for these vacancies. This was attempted in this wise. It having been decided that the out-door staff should, like the in-door staff, be divided into a medical and a surgical staff, a division was made, placing the two gentlemen who are about to leave it to become specialists—on the surgical staff. This would make two surgical vacancies. One of the candidates, whose entrance to the Hospital is opposed by the medical clique in power, is better known as a physician than as a surgeon, although like the *entire* medical profession in Montreal (except two oculists) he is a general practitioner. This fact was made to do duty against him a year ago, and in the manner indicated preparation was attempted to be made, for its doing duty again. By the determined action of two members of the Medical Board, the attempt was frustrated. The division was postponed, and now practically these two men hold the game in their hands. Nevertheless the animus was shown.

Is it not time that a truce was called between the two parties, and an arrangement come to whereby the two vacancies shall be filled by a candidate from each being elected. Such it seems to us should be done. Each should then be satisfied, the hospital would be the gainer, and a calamity which now threatens the institution be averted.

Then again it is a question worthy of consideration whether it would not be wise to increase the

staff. There is plenty of material to give work for at least four more men. That such an increase would be highly advantageous does not, we believe, admit of a doubt. One has only to visit the wards during the session of our medical school, to be convinced of this. The crowd of students that follow the present staff is absurdly large, both as regards benefit to the students and the welfare of the patient. This fact is recognised by the students themselves, and is a loud cause of complaint among them—moreover it drives students from the city. We know this to be a fact. Montreal should be the chief centre of medical education in the Dominion. It was at one time. We doubt much if it is now. The oldest medical school in Montreal had, one year ago, only increased about eleven students in nineteen years. And this notwithstanding the fact that many students have come to Montreal from the Maritime Provinces since Confederation, who previously went to the States for their education. In Toronto, during the same time, one of its medical schools has increased from about seventy to nearly three hundred students. All this increase is of course not due to the cause we complain of, but some of it is. The staff of the Toronto General Hospital is arranged so as to suit nearly all. It is useless for us to praise our method of clinical instruction. We know it to be good. We would not wish for better men. But to have to stand on the top of a bed, climb a chair, or force through a dense crowd of fellow-students to get a glimpse of a patient, will sooner or later drive students from us. Nay it is doing so every year. We believe the policy which perpetuates this to be foolish in the extreme. It is suicidal to the interests of Montreal as a medical teaching centre. It is against the interest of the medical school which, having the present medical control of the hospital, fears the admission of the member of another school. In many other cities the members of different schools are attached to the same hospital and they work harmoniously together. We do so here in private practice—why it cannot be done in hospital work we fail to see.

It can be done. Thirteen years ago, when a new English medical school was started in Montreal, and its students began attendance at this hospital and applied for admission to its clinical lectures, it was said there would be disagreement with the students of the senior school. We have

yet to hear of the first difficulty. The lesson of the students might with profit be studied by some of the professors.

And why this persistent opposition from a certain quarter to the men of this junior school. Is it not a fact that two of the now leading men of the senior school, thirty years ago, were the organizers of a rival to their *Alma Mater*. That it only existed one year was not their fault. If any *animus* existed, it was in the formation. That it was not necessary, or that its promoters did not realize the position it would of necessity occupy, is proved by its early demise. That this junior English school in Montreal is now entering on its fourteenth session, proves that at least its promoters knew what they were doing. Having existed that long—having battled quietly and honorably for its rights, with at least the approval of a large body of the public, both professional and lay, it is not likely now to succumb. Its power in hospital matters is year by year growing stronger. The time will come, and perhaps soon, when its star may at least equal that of its rival. If we know its men, it will then only ask for, as it does now, equal justice. Are the men of its rival willing to give it? It is for them to say.

LACTOPEPTINE.

This well-known remedy is constantly gaining in favor with the profession in treatment of bowel complaints in children, especially in cholera infantum. Our own experience in its use in the latter affection, leads us to bring it again under the notice of the profession at this season of the year. It may be combined with bismuth, calomel, ipecac, or any other agent that may be indicated. It aids digestion, controls the action of the bowels, modifies the secretions promptly, and produces no disagreeable after effects.

THE LATE DR. LANDRY.

Dr. J. E. Landry, died in Quebec on the 10th of June. He was a prominent medical man in that city, but for many years has devoted himself to his interest in the Beauport Asylum, of which he was one of the proprietors. He left a considerable fortune.

THE CANADA MEDICAL ASSOCIATION.

The annual meeting of the Dominion Association will take place in Montreal on the 25th, 26th and 27th of August, and a large gathering is expected. The attendance of at least thirty or forty prominent English medical men, who come to Canada to be present at the meeting of the British Association for the Advancement of Science, is already assured. Among them is Mr. Lawson Tait, who has promised an address on Abdominal Surgery. The committee of arrangements in Montreal have been at work for some time, and we can assure those who may come of a hospitable and pleasant meeting. Gentlemen who propose to read papers should at once notify the acting secretary, Dr. James Bell, Montreal.

Local and General.

In the absence of excursions into the country and to the seaside, the means by which our neighbors across the line fight off the effect of the summer heat from the children of the poor, it seems to us that a temporary children's Hospital or Sanitarium might be established on Nun's Island or in some other convenient locality. So far we have had a cool summer, and comparatively little cholera infantum and other diarrhoeal complaints, but the general practitioners know how many children die in Montreal every summer for the want of a few weeks of pure and fresh air, and a rational diet. Even if no more than half a dozen large tents or *marquées* could be obtained, it might save many lives. In urgent cases the mothers could accompany the children, and might be available in assisting to do the work about the encampment. It would also form a valuable convalescent hospital for city institutions.

Greig in his "Enigmas of Life" points out how nature (with a large N. P.) weeds out the weakly, and the diseased, by such means as this very infantile cholera, and discusses in a very interesting way how man has stepped in and modified the force and changed the direction in many instances of "Natural Selection." He seems to be undecided in his conclusion as to whether such interference is likely to be prejudicial to the race or otherwise. It appears to me that Nature (whether spelled with a large or a small N), is supremely indifferent to the fate of the indivi-

dual and affords us little comfort in the matter. Until further experience teaches us otherwise we are bound to go on, and not only secure the life, when we can, but also prolong the existence, if nothing more is possible, of the weakling, even if he, in the meantime, reproduces his kind and spreads abroad his doubtful influence.

Still, those of us who incline to the belief that it is better for the community that there should be a weeding out of the sickly may find good examples of the desired *end* even if we revolt at the means employed for its attainment. These might be styled cases of "artificial selection," and it reaches its highest state of perfection in old Laconia, where only sound, vigorous children were allowed to live. When a Spartan woman was found to be pregnant, they hung up pictures of the handsomest men about town in her bed-chamber so as to produce a favourable effect upon the fruit of her womb. It is upon this principle, we presume, that we so often find a more or less artistic representation of the three Graces in many modern rooms sacred to the goddess Lucina. I have not yet learned, however, whether that picture is intended to "impress" the expectant father or the mother.

If we really must have Asiatic cholera here next summer, or the following one, shall it find us prepared or unprepared? If the latter, will the consequent widows and orphans have a claim upon our city government? If a man trips over a deficient sidewalk or falls upon an icy pavement to the detriment of his long bones, he has good grounds for an action at law against the party whose duty it is to keep the pathways in proper order—why is it not then allowed to proceed against a corporation who wilfully and criminally poisons the people under its care by dirty lanes and deficient sewers, and by allowing them to live in reeking man-traps, facetiously termed tenement houses? As soon as the various officials and others connected with our local Health Office, get through squabbling among themselves, perhaps they will turn their gigantic intellects upon these questions, and consider them.

In Cable's "Dr. Sevier," the doctor is asked to subscribe towards an asylum overcrowded with orphans in consequence of a late epidemic of yellow fever, and while putting down his name for

a large amount delivers himself thus: "In old times we used to go into monasteries, now we subscribe to orphan asylums. Nine months ago I warned this community that if it did not take the necessary precautions against the foul contagion that has since swept over us, it would pay for its wicked folly in the lives of thousands and the increase of fatherless and helpless children—We deserved it!"

Then he reads the heading of the subscription list: "God in his mysterious providence—oh, sir!—what a foul, false charge! There's nothing mysterious about it! We've trampled the book of Nature's laws in the mire of our streets, and dragged her penalties down upon our heads!

A community has got to know these laws and keep them or take the consequences—and take them here and now, on this globe—*presently*."

Who has run away with the Protestant Insane Asylum? I wish somebody would clear out with the sectional differences that makes it impossible in this Province for Protestant and Catholic citizens to unite in supporting at least one good insane asylum near the city of Montreal. Let the local legislature give a *per capita* grant and the co-religionists of the patient make up the balance necessary for his proper treatment.

Looking at the Longue Pointe Asylum one is impelled to wish for a little less religion and a little more medical science in its internal economy.

Just what religion has to do with an Insane Asylum would puzzle most theologians to declare. I have always myself been under the impression that the various churches preferred their adherents in the sane condition and did not hold them responsible (after the legal style) when *non compos mentis*.

Miss Jewett's "A Country Doctor" is quite worth reading. There are many passages in it which remind one—at a respectable distance however—of the musings about our profession which dot the pages of "Elsie Venner." I actually came across a doctor the other day, and he was no mean representative of our Art, who had never read the latter book. I begged him, in view of the

uncertainty of life, to read it at once and to read the medical portions at least three times.

Is the House Surgeon of the Children's Hospital, Hackney, London, the inventor of the rubber drainage tube commonly used in cases of empyema.

In a recent paper read before the Ontario Medical Association, Dr. J. P. Brown seemed to make that claim for him. See *Canada Lancet* for July.

I give his exact words: "He (the House Surgeon), remarked that they always found difficulty in securing the tubes so as to avoid the possibility of accident; and that he had devised a method which secured perfect safety. He showed me the arrangement, and also two in actual use there. The end of the tube was split in quarter segments longitudinally. A circular rubber cap was then made with a hole in the centre large enough to admit the tube. The ends were passed through and by the application of heat welded on to the upper surface of the cap. The cap would thus effectually prevent the possibility of slipping in so much dreaded."

A few days ago I extracted a hair (*cilium?*) from the upper canaliculus of a patient's left eye. He thinks it must have found its way there from some other eye as it was of quite a different color from his own blepharides!

P. A. LAVER, M.D.,

Montreal July 16, 1884.

HYGIENIC FOODS.

The early practice of our oldest physicians, as well as the trade of many of our chemists a quarter of a century ago, prove that large quantities of "groats" and "prepared barley foods" were sanctioned and used by the profession. They were prescribed for children and invalids, and the results were most satisfactory. Of late years the use of these foods has materially declined, to the detriment of many whose diet should be almost restricted to fruit and cereals. A chief cause of the falling-off in the use of cereal foods has no doubt been the careless manner of their preparation, and we are glad to note that one firm at least has realized the importance of preparing the various grains so as to preserve all their valuable qualities, while presenting them in attractive form,

and treated in the light of all the scientific progress of the time. We have been led to these observations through receipt of a circular from Messrs. Fish & Ireland, of Lachute Mills, P. Q., who offer us the following valuable bill of fare:

Dessicated Wheat, (Hulled and Rolled);

Rolled Oats, (Oat Meal);

Dessicated Barley, (Hulled and Rolled);

Dessicated Rye, (Hulled and Rolled);

Patent Prepared Pea-Flour, (for Soup, Brose, &c.);

Superior Family Groats, (Pure and Fresh);

Patent Prepared Barley, (Pure and Fresh)

Parched Corn, (Green Corn):

Whole Wheat Meal, (made of the whole kernel of wheat except the outer bran);

These foods afford not only nutritious and delicate diet but also assist in laying the foundation of a strong muscular development as well as brain and nervous vitality. They contain a full proportion of diastase and the nitrogenous constituents so essential to the health and vigorous growth of the body in the earlier stages of life, and for the reconstruction of systems 'run down' with dyspepsia and other affections of the digestive organs. We have tried several of the foods above mentioned, and have no hesitation in recommending all the preparations of this house as worthy the confidence and endorsement of our readers.

Dr. Irwine (M.D. McGill, 1866) is now on the "Circassian" of the Allan Line, as Surgeon. He was for a number of years in the African Court, being held in high repute there. He was Physician to the King.

PRACTICE FOR SALE.

A competent general practitioner can learn of an opportunity to purchase an active practice, averaging \$3,000, located in a delightful region, famous as a resort for lung patients.

Good home and road outfit, with some furniture if desired. Reason: going to the city.

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