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THORACIC PHENOMENA OF INFLUENZA,*

BY W. J. GREIG, B.A., M.D., L.R.C.P. ENG., TORONTO.

In the early part of 1892, Pfeiffer, an assistant in Koch's laboratory in Berlin, discovered and described a bacillus which he claimed was the causative agent in influenza. Almost simultaneously the same organism was described by Kitasato and by Canon. A few months later, Klein of England, in a communication to the Government Board, corroborated the statements made by Pfeiffer and added that he had also found the bacillus in the blood. Not only had they found the bacillus in every case of influenza examined, but they had been able to produce the disease in susceptible animals, especially monkeys. Injections of cultures into the lungs through the thoracic walls, as well as inoculation on the nasal mucus membrane, produced attacks of the disease. The next communication of importance on the subject was by Drs. Parsons and Klein, in a Government Health report, referred to in the *Lancet* of August, 1893. Dr. Klein states that he only discovered the bacillus in the blood in a very few cases and adds in italics, "that any bacilli of influenza that may gain access to the circulation lose their vitality and are present in the blood only as dead bacilli." The report continuing, advocates caution in accepting this organism as the specific bacillus of influenza, on the ground that sufficient time has not yet elapsed to ascertain whether it can be found in any other disease or not.

Prof. Koch laid down three postulates which in his opinion any organism must conform to,

before it can be recognized as the causative agent in any particular disease. These were :

1st. The organism can be found in all cases of the disease.

2nd. It cannot be found excepting in this disease.

3rd. With pure cultures, the disease can be produced experimentally in susceptible animals.

So far then the organism described by Pfeiffer fulfils the requirements of the 1st and 3rd postulate, but more time is necessary before the 2nd or negative postulate can be proved.

The bacillus in question is small, not so large as that of mouse septicæmia, two or three times longer than broad, and staining with difficulty. It was found in enormous numbers in the sputa, the number varying with the degree of fever, the higher the fever the more bacilli. They were also found in the pus cells of the sputa. They could be cultivated freely in blood at the temperature of the body and were affected by changes in temperature and by drying.

Almost every disease to which the thoracic organs are liable may be set up, or, if already present, may be intensified, by the action of the influenzal poison. Bronchitis, lobar and lobular pneumonia, phthisis, abscess and gangrene, asthma, pleurisy in its different aspects, endocarditis, pericarditis, neuralgia, weak heart, and functional disturbance so called. This list is so extensive that I cannot pretend to discuss them all, but will attempt to deal with those of most frequent occurrence.

And first, a few words as to diagnosis. When are we justified in calling any disease of the thorax influenzal in character ?

1st. When the disease is epidemic there should be no difficulty in recognizing the condition, although I fear the mistake is sometimes made of calling everything influenzal. But sporadic cases occur after the epidemic has died out, which may be difficult to recognize.

2nd. When the sickness is introduced by an attack of those well-known nervous muscular pains, such as intense headache, backache and general soreness.

3rd. If the thoracic disease is accompanied or followed by a prostration out of proportion to the amount of local disease present, we would be safer to call it influenzal in character.

*Read before the Ont. Med. Association, June, 1894.

Of the catarrhal processes which form a part of influenza, bronchitis is the most common. It usually commences as an ordinary bronchitis, but rapidly advances to the small tubes, when serious symptoms are set up, especially in the weakly and in the aged. The expectoration is often scanty, but may become copious. It is always sticky and tenacious and difficult to raise. All sorts of râles may be heard in the chest, and some writers have advanced the theory that many of these sounds are reflex and of central nervous origin. The tendency of the disease is to attack the small tubes, setting up a capillary bronchitis, which is soon followed by atelectasis and lobular pneumonia.

A writer in the *British Medical Journal* makes the statement that the bronchitis is more apt to attack the right than the left lung, and that the left lung may escape altogether. His theory is that the bronchitis is due to aspiration of the influenzal bacillus, and that the right lung is preferred because the right bronchus is larger and more horizontal.

Broncho-pneumonia is a very common complication of the disease following capillary bronchitis. Osler states that capillary bronchitis rarely exists apart from lobular pneumonia. So much is this considered the case that recent text-books on medicine do not describe capillary bronchitis as a separate affection. I have no doubt but that in this fact is to be found the explanation of many of those cases of bronchitis which are so rebellious to treatment. It also explains why the constitutional disturbance and the depression are out of proportion to the local condition apparently present. There is nothing peculiar about the broncho-pneumonia following influenza, and nothing more need be said about it at present.

Congestion and Lobar Pneumonia.—An acute localized pulmonary congestion has been described following influenza. French writers have a great deal to say about acute pulmonary congestion. English writers doubt its occurrence. However, after influenza there does occur a peculiar localized condition which may be difficult to classify. I well remember a case in my own practice in which at the posterior base of the left lung there was dulness on percussion, intensified voice sounds with indistinct tubular breathing, but neither rusty expectoration, crepitant râle or severe con-

stitutional symptoms. Even after his recovery I was uncertain whether I had to deal with a localized congestion or a pneumonic consolidation. Perhaps the best evidence of the existence of these congestions is the fact that free action on the bowels will improve the physical signs. Out of the *post-mortem* room I doubt the possibility of distinguishing between a localized congestion and an anomalous or atypical pneumonia, in which form the latter disease is often introduced to our notice after influenza. Allow me to state more explicitly what I mean by anomalous or atypical. I mean a pneumonia which has indefinite symptoms, which is slow and insidious in onset, and which does not run a normal course. There may be no chill, no vomiting, no rusty expectoration, no crepitant râle, little or no cough, no increase in fever or in respirations, no alteration in the pulse-respiration ratio. The temperature may be very aberrant. It may run up very high, perhaps to 106° F, drop to a low point, and then run up again in the same day. Dyspnoea and cyanosis may be marked, but are due rather to the associated bronchitis than to the pneumonia. But physical examination will show dulness on percussion, tubular breathing and bronchophony. In fact there will be marked disproportion between general symptoms and physical signs. The character of the pneumonia is modified by the poison of influenza, and a marked feature of the average case is asthenia.

That pneumonia is one of the most frequent complications is well known. I have seen several statistical tables from some European and American hospitals, and they show conclusively that the number of cases occurring during the influenza epidemic was almost double compared with the number of cases during the corresponding periods of other years. I wish to emphasize the fact that pneumonia is a complication, not a part of the disease as bronchitis is, and therefore avoidable in many cases. The usual cause assigned for the increase of this complication is that patients resume their ordinary mode of life too soon after the influenza, forgetful or careless of the devitalization following the disease. This, of course, is an avoidable cause, but there is something more in it. To produce an attack of pneumonia, two things are necessary: 1st, the presence in the tissues of Fränkel's pneumococcus, which has

been found by Netter in the buccal secretions of 20% of men in perfect health. So that this agent is very likely to be present. 2nd. Any devitalizing or debilitating cause, such as a chill, exhaustion, or the prostration following an acute illness. Therefore, it is clearly seen in what way influenza is a direct predisposing cause of lobar pneumonia. Many may think that with a patient in bed or in a warm room there is no danger of any complication. You would naturally think that in typhoid during the 2nd or 3rd week there was little danger of pneumonia, but the authorities state that it occurs in from 8% to 10% of all cases. In exactly the same way, pneumonia may occur after influenza, and may be so slow and insidious in development, and so atypical in character, that unless sought for may be overlooked. You may ask whether a pneumonia coming on in this way can be avoided or not. It can just so far as you can combat the debility. In treating the acute stage avoid the coal-tar products, or, if necessary to use them, give stimulants also. And, after the acute stage is past, give tonics and stimulants, quinine, iron, nux vomica or its alkaloid, caffeine, ammonia, ether, etc. Avoid everything that can possibly depress.

Tuberculosis.—I have not much to say on this subject. In the dreadful depression which we have all seen so often and perhaps felt, the tubercular diathesis, if present, is very apt to assert itself. A suitable soil is provided for the growth of the bacillus of tuberculosis. I find that the journals contain reports of numerous cases of phthisis developing after influenza. I. W. Irwin, in the *American Practitioner and News*, reports six cases developing in patients, with a family tendency thereto. Patients already suffering from the disease are hurried on towards an earlier grave.

In a case of my own, in which in the early part of the winter the tubercular process in the lung appeared to be at a standstill and the condition of the patient otherwise improving also, I had hoped for a permanent improvement, with, perhaps, years of good health. Unfortunately in January of this year, she developed a very severe, acute attack of influenza. When I saw her, after she had been sick for a week, I found her terribly prostrated with a weak, irregular and intermittent pulse. The tubercular process which had been limited to

the upper half of the right lung, extended rapidly after this involving the balance of the right lung, and shortly after the process showed itself in the apex and at the base of the left.

Affections of the Heart and Pericardium.—With regard to inflammatory diseases of the heart I have very little to say, beyond noting the fact that cases of endocarditis and pericarditis have been reported following influenza. Dr. Burney Yeo has reported a case in which he watched the development of an aortic regurgitant murmur after influenza. When we enter the field of functional heart disease we are in deep water. The term neurosis has been applied to these cases lately and I believe that it is a much better term. All sorts of cases have been described in the journals. Here is a short list: bradycardia, tachycardia, arrhythmia, neuralgia, weak heart, collapse, acute dilatation with pulmonary congestion.

I desire to read to you a report of four very unusual cases which have been carefully described in the journals. In the *British Medical Journal*, 1892, Dr. Yeo reports the following. "A young man was suddenly attacked with dyspnoea, and palpitation with irregular heart and pulse. This was soon followed by anasarca, albuminuria, hepatic enlargement, and pleural effusion. His condition otherwise was good. No pain, no fever, regular bowels and good appetite; no valvular lesion. All his symptoms were due to a rapidly produced, acute cardiac asthenia with dilatation. The only possible cause that could be ascertained was an attack of influenza six months previously, during which he was laid up for three days with an acute pain in the back. Dr. Yeo offers in explanation of the symptoms, an infection of some sort, an affection of the coronary arteries, or a nerve lesion."

Dr. West, Assistant Physician to St. Bartholomew's, before the London Harveian Society describes the following case, *Lancet*, 1894: "A man of good physique, in middle age, had a temperature of 103° F. for two days, after which it became normal, and was associated from the first with attacks of collapse. These would come on without any warning; the patient would turn pale, could speak only in a whisper, and felt as if he were falling through the bed; pulse barely perceptible at the wrist and quite regular. In fifteen or twenty minutes he would be all right.

These attacks occurred three or four times daily during the fever, gradually became less frequent and severe, but did not entirely disappear until the post-febrile depression had passed off and the temperature had risen again to normal. In this patient the attack of influenza was otherwise mild." Dr. West continuing says, "That these cases of collapse occurred so frequently with him that he found himself unconsciously speaking of the collapsing form of influenza."

In the *British Medical Journal*, 1892, Dr. St. Clair Thompson, M.R.C.P., London, reports three cases of what he calls cardiac neuralgia, one of which proved fatal. I quote particulars of this case: "Stout gentleman, æt. 39 years, took little exercise, and smoked on an average ten cigars a day, had apparently recovered completely from an attack of influenza. Eight days afterwards he had a business meeting at his house at which he smoked, drank and had a good dinner. Next morning he suffered from an attack of flatulence and vomiting, with a constant wearing pain midway between the nipple and the shoulder. Pulse 90, soft, regular and compressible. During the day the heart pain diminished without ceasing entirely, and the patient was well enough to be out of bed. At midnight the pulse was 88 and regular; an hour later, on raising his head to swallow a pill, he suddenly fell back dead. There was no autopsy."

Dr. Thompson refers to two other cases very similar in character, but not fatal. These cases differed from true angina in the absence of evidence of arterial or cardiac disease. His opinion was that the symptoms were due to the effect of the influenzal poison on the cardiac nerves.

In the *International Medical Magazine* for January, 1893, the following case is reported by Dr. J. H. Platt, of Lakewood, New Jersey: "A young woman, æt. 25 years, had been under the Dr.'s care for several years for heart symptoms, associated with a mitral regurgitant murmur. In December, 1891, she had an attack of influenza, after which lobular pneumonia developed. Her convalescence was slow, associated with great prostration and with attacks of collapse. On the evening of January 11th, at 7.45 p.m., the pulse was 102, weak and small. Fifteen minutes later, the pulse was 58, larger but weak and soft. Collapse occurred an hour after. The pulse remained

at 52 for eighteen hours when it suddenly changed to 104. Later in the day it was 96, and at 5 p.m., suddenly changed to 48. This interchangeable pulse continued for eleven days, and on several occasions the Dr. with his finger on the pulse observed the change taking place. It would occur in this wise: the pulse being 100 to the minute and regular, a beat would drop out, then after a few beats another, and after a shorter interval a third and so on, at lessening intervals until under the finger a regular pulse was felt of 50, larger and softer than the former. After a time the process would be reversed and the frequency doubled. The heart sounds corresponded with the pulse beats. Finally complete recovery took place."

I believe that Drs. McMahon and Graham of this city, saw a case in which the same phenomena occurred.

A study of these four cases, so widely different from each other in symptoms, gives us the best idea of the complex conditions produced in the heart by the influenzal poison.

How can we explain this diversity? What is the pathology of these cases? I regret to say, that of absolute knowledge we have none. We can argue from our general medical knowledge that such a complexity of symptoms can be produced only by septic causes. Under these circumstances we may obtain ideas as to causation and its mode of action by analogical reasoning from a disease of a similar nature, such as diphtheria. Of course such a method of reasoning holds good only on the assumption that influenza is a disease of bacterial origin, which there is good reason to believe.

You are aware that from the specific germ of diphtheria a tox-albumin has been separated. When this is injected into susceptible animals, it produces paralysis, nephritis and albuminuria. In other words the sequelæ of the diseases are produced. And, in addition, the same pathological changes are found on *post-mortem* examination. Every change described by Oertel, in human diphtheria, is paralleled in the disease produced in animals by the injection of this tox-albumin. The arteries may be altered in character, the capillaries may show extensive hyaline degeneration and necrotic areas in deep-seated organs may be produced.

Assuming then, that influenza is a bacterial disease, of which there is substantial evidence; assuming also, that the symptoms and many of the sequelæ are nervous in origin, which is a widely accepted opinion; assuming also, that the influenzal bacteria do produce a poisonous albumin, as other bacteria do; are we not justified in concluding by analogy from diphtheria, that the symptoms and many of the sequelæ are produced by the circulation in the tissues of a tox-albumin. Further, that the effects, sedative in some cases, irritant in others, sometimes to the extent of producing a neuritis, are produced by the action of this poison on the nerves and nerve centres, with a preference for the pulmonary, gastric and cardiac branches of the pneumogastric. In the case of the heart, the action may be on the circulatory centre in the medulla, on the inhibitory or accelerator fibres of the pneumogastric, on the cardiac plexus or on the ganglia in the heart substance. The result of the poison's action may be as in the case of diphtheria, to produce degeneration of the coronary arteries with consequent mal-nutrition of the heart substance, or to produce areas of necrosis in the walls of the heart or on the endocardium.

Such, Mr. President, is I believe a workable hypothesis of the disease. Such is the only hypothesis, correct or not, which on our present knowledge, we are justified in making. It furnishes a basis for treatment, which if kept in view will produce an intelligent and perhaps a more careful treatment.

APPENDICITIS AND ITS SURGICAL TREATMENT.

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There has been some unnecessary confusion as to the term to be employed in describing this affection. Typhlitis, perityphlitis, paratyphlitis and appendicitis are words that have been used in a somewhat indiscriminate manner so as to convey to the minds, of some at least, of the profession, that these diseases are separate and distinct entities, incidentally attacking the right iliac region. This classification is very apt to confuse the mind as to the pathological condition under-

lying a given case. The multiplication of terms is also unfortunate in that it is clinically incorrect. Acute inflammation confined wholly to the cæcum probably never occurs. The appendix would soon become involved as well as the surrounding peritoneum, and it would be then that we would have presented the clinical phenomena of the disease. As to perityphlitis, this is a local peritonitis, secondary to the inflammatory process in the cæcum or appendix, with or without suppuration; it therefore should never be used to designate the primary disease.

The term paratyphlitis I apprehend is simply a reminiscence of the time (not long past), when the anatomy of the part was not well understood, and when the appendix was supposed to lie behind the peritoneum, and it was thought that inflammation of the viscus was liable to invade directly the retroperitoneal tissue. There is no longer, I believe, any doubt that the appendix is normally wholly surrounded by peritoneum, and that disease of the organ is at first entirely intraperitoneal and cannot very readily at all events reach the extraperitoneal cellular tissue. In preferring the term appendicitis I am guided also by the statistics at our disposal. Without citing more extensively, I may remind you that in 18000 cases of this iliac disease reported from Germany, 91 per cent. showed decidedly that the appendix was the origin of the trouble. Anyone may readily verify the same from English or American figures.

The question of surgical interference in appendicitis is still being very ardently canvassed on this continent, some going so far as to say that a justifiable operation is a rare contingency; others maintaining that all such cases should be handed over to the surgeon within twenty-four hours of their development.

Both of these contentions are extreme, and yet either might be justified by a limited observation of cases. The disease varies within a very wide area as to its severity, or, perhaps, I should rather say to its course. There are no doubt cases which run a mild course, recover without incident under medical treatment, and do not tend to recur as the result of any surviving lesion. Others progress rapidly to suppuration, perforation, perhaps general peritonitis and death. Still a third class of cases though apparently recovering under

medical treatment, yet tend to recur again and again until the patient succumbs to an attack more serious than its predecessors. If then we could be enabled to establish a diagnosis in these different forms of disease at a reasonably early period, we would certainly be possessed of important data for our guidance in the future conduct of the case. Let us then for a moment look at some of the pathological conditions underlying the different forms of the disease to which I have referred, and the more prominent symptoms resulting therefrom.

The first form of the disease, namely, that comparatively mild variety which tends toward uninterrupted recovery under medical treatment, is probably in the vast majority of cases associated with accumulated masses of hardened feces in the cæcum as the primary causative factor. These should never be looked upon as cases of appendicitis, but I wish to include them here (1) because I believe they are not infrequently so diagnosed and (2) because such a cause may give rise to true inflammation of the mucous membrane of the appendix, which, once the cause is removed readily recovers without ulceration. Outside the symptoms of this condition there are at least two reasons for this conclusion both necessarily of a negative nature. (1) Statistics show that in nearly every instance when an operation has been deemed necessary the appendix has been found to be involved rather than the cæcum. (2) If in these mild cases the appendix be the part primarily involved (through the effect of fecal accretion or foreign body lodged therein) then it is a mystery to me how merely medical treatment can so readily effect a cure. Remember the muscular coat of the appendix is but poorly developed, and the tendency of a foreign body lodged within the process would always be toward ulceration and perforation, and not removed by the natural opening into the cæcum by vermicular action.

Granting then that the cæcum is the seat of trouble in these milder cases, what symptoms would we expect to accompany such lesion? A large, irregular, somewhat ovoid tumor in the right iliac region, usually not well defined by rectal touch, doughy in feel rather than hard, present from the outset of the disease with no distinct point of tenderness but a tender area of considerable dimensions; pain and temperature not

so extreme as in true appendicitis, and the former not so liable to radiate to other points; a history of constipation and scibilous feces, and usually of some grave indiscretion of diet. This class of cases may be confidently left in the hands of the physician.

There is another cause that may sometimes underlie these easily cured cases, viz., the sudden twisting or bending of the process upon itself owing to the movements of the cæcum. This may produce a slight inflammation of the partially occluded appendix, which may subside in a short time without involving the serous covering, the appendix having righted itself again under the influence of a saline. These attacks are very sudden in onset and subsidence, the pain is colicky, and there is no evidence of tumor.

The second class of cases to which I have referred, presents a very different problem for solution. Here the progress of the disease is toward suppuration. The cause of this condition is usually the lodgement of an enterolith or a foreign body in the appendix with occasional cases (which we shall not now consider) resulting from extension of the typhoid or tuberculous ulceration in the neighboring intestine. Such a case is frequently ushered in by a rigor followed by high temperature; a point of maximum tenderness may be early localized; the pain is sharp and radiating to thigh, testicle or bladder; the tumor appears later in the disease; when deeply located may usually be outlined per rectum, is oblong and indurated, later becoming softer, and follows the course of the appendix. Vomiting is often a distressing symptom, and later the indications of pus formation present themselves. No history of constipation is necessarily made out. While these symptoms appear to the mind as the logical sequence of the pathological conditions underlying this form of disease, and while clinically they are in many cases quite sufficiently obvious to be conclusive, yet I cannot too strongly urge the fact that some cases of perforative appendicitis begin and progress most insidiously, and that the attendant should be unwavering in his watchfulness of all local and constitutional conditions, and be prepared at all times for immediate operation.

In this form of disease surgical interference is of course called for. The two debatable questions are, (1) When; (2) How to operate.

In answer to the first of these questions many American surgeons have urged the operation at the earliest possible moment after the diagnosis of the appendicitis is even reasonably clear; while the more conservative practice in European countries has been to wait until the presence of pus has been defined. In this country the latter method is, I believe, generally favored. Arguments may be advanced in favor of both views, but as my paper threatens to become quite too long for your kind indulgence, I shall dismiss the early operation entirely (trusting to hear its advocacy in the discussion) and say just a word in defence of the later incision.

The great objection that has been urged against this method is the danger of perforation of the abscess into the general peritoneal cavity. Now the appendix being entirely surrounded by peritoneum the abscess is intra-peritoneal at first, but is shut off from the general cavity by inflammatory adhesions through which the pus must penetrate before invading the peritoneal cavity. I think experience will bear me out in saying that this is an incident not likely to occur earlier than the fourth or fifth day of the disease. Besides, this is not the only avenue of escape for the pus. It may, and has, burst into the bladder, the adjacent intestine, or through the anterior or posterior abdominal wall, and thus a spontaneous cure may result. Although this is not the most desirable termination of the disease, yet we should consider its possibility before resorting to the too early use of the knife.

I would also remind you of the difficulties in the way of making an absolutely certain diagnosis, and of the fact that appendicectomy is not a trifling operation to be lightly undertaken by the general practitioner. For these reasons, while the possible necessity of a very early operation in the more acute cases should not be lost sight of, it seems to me the preponderance of evidence is in favor of judicious and watchful delay.

In answer to the second question, viz.: how to operate, there is more unanimity. The incision should be over the cæcum, parallel with, and one and a half inches above, Poupart's ligament, three or four inches long, terminating externally to the deep epigastric artery. Should any evidence exist of adhesion to the anterior abdominal wall one extremity of the incision should enter the

peritoneum outside the dull area, otherwise the bowel may be wounded. Indeed the whole incision may be made at a higher level if there be an extensive dull area. When the pus cavity is reached, infinite care should be taken to avoid breaking down adhesions. With this object in view, no rough handling of the parts should be indulged in for the purpose of finding the offending process. Should it be readily discovered, it may be ligated off close to the cæcum and removed. The abscess cavity should be carefully washed out, a drainage tube inserted and the wound closed. Liquid diet in small quantities. Bowels restrained for six days, then opened by enema.

Now, briefly in reference to the third class of cases, viz.: those of relapsing appendicitis. Here, too, the appendix is the offending member. It is true we do meet with recurring attacks of typhlitis due to accumulation of fæces in the cæcum, but each of these cases is in its nature primary, and obviously due to constipation or errors in diet, and the attacks do not tend to increase in severity. They are, in short, avoidable cases with a more or less distinct history as to cause. The pathological condition underlying true recurring appendicitis, however, is, as a rule, some abnormal position of the appendix. It has become twisted or bent upon itself and has become fixed in the position by adhesions, and its lumen has become either greatly narrowed or entirely shut off from the cavity of the cæcum. The natural secretion of its mucous membrane accumulates and distends the process, with the result of a local peritonitis, which gradually passes away only to recur on exposure to cold or slight injury, or even without any apparent cause. The attacks are apt to increase in severity until finally the patient dies or is obliged to consider himself a chronic invalid. Here there is little tendency to suppuration, and we may wait for complete subsidence of an attack before resorting to the use of the knife. The question as to how many attacks should qualify the patient for the operating table is a difficult one to answer. Each case must be decided upon its merits, and the patient himself must assist in the decision. Certainly, if he has had two or three attacks of increasing severity one should no longer hesitate. Then an incision of three inches in length may be made in the usual position and the appendix sought for. We must be prepared

for numerous adhesions and, perhaps, much confusion in the anatomy of the part. As a rule, the process will be found behind the cæcum pointing upward and toward the left, or else downward into the pelvis.

The more firm adhesions should be cut, not torn, large, flat sponges used to shut off the field of operation from the general cavity, and bleeding arrested at once, by ligature, if necessary. If the process have a mesentery it should be ligatured in sections and cut and the appendix removed after clamping close to the cæcum. The mucous membrane of the stump should be then drawn out and ligated, then carefully inverted into the cæcum. The remainder of the stump may then be buried by a few Lembert sutures taken in the adjacent wall of the cæcum and crossing the face of the stump, thus effectually covering it. The further protecting of this danger point by stitching to the site some loose portion of omentum or mesentery I have not tried.

I have not spoken of the difference between recurring appendicitis and the relapsing appendicitis described by French writers, because it must be often difficult to define and would not materially alter the treatment. Nor have I mentioned the differential diagnosis between appendicitis and other diseases in the locality, such as malignant disease of the ileo-cæcum. Here, at least, exploratory incision would be called for.

The following case may be of interest :

Mr. B., a young married man, æt. 28, has had numerous attacks of appendicitis, extending over a period of 12 months. These would come on suddenly with severe pain in the region of the appendix, followed by elevation of temperature, tenderness in McBurny's point and every indication of local peritonitis. The attacks would last for about a fortnight, during which the patient would be entirely unable to follow his business (that of a miller), and would be in bed most of the time. The attacks became worse and more frequent until the patient greatly dreaded their return, and began to look upon himself as little better than a chronic invalid. His physician, Dr. Niddrie, of Creemore, urged an operation for his relief. This was consented to, and the doctor asked me to go up and operate, which I did on the 12th of the last month. I found the patient otherwise in excellent health, but anxious for any

operation that would relieve him from his enemy. As all symptoms of the last attack had subsided, I found indistinct evidence of tumor upon deep pressure over the appendix. Relying confidently upon the diagnostic acumen of the attending physician, I unhesitatingly complied with the wish of the patient and proceeded with the operation. The cæcum was adherent to the anterior wall, and the peritoneum was opened above and external to it when the adhesions could be readily separated. The appendix was found adherent throughout to the posterior wall of the cæcum, and doubled upon itself like the letter V, and considerably enlarged, the distal end especially so.

Yesterday the doctor wrote me as follows: "The temperature on the day following the operation reached 99.4°, on the second day, 100.2°, on the third, 99.1°, on the fourth, 99.1°, on the fifth, 99.3°, and on the sixth, 100.3°, after that normal. Diet for first four days, nothing but buttermilk and cracked ice, then allowed some chicken broth; at the end of a week allowed some fish, eggs, etc. Administered no sedative but morphia hypodermically. On the sixth day after the operation gave two enemata of soap and water, followed two hours later by an enema of glycerine. This resulted in a copious evacuation, which entirely relieved the tympanites from which he had been suffering several hours prior to the enemata. Removed the stitches ten days later. Wound perfectly healed. Patient feels splendidly."

Selected Articles.

INTRA-UTERINE MEDICATION.

Before the antiseptic era this treatment had been associated with various kinds of dangers. The simple passing of the sound had frequently given rise to grave infection, and even fatal peritonitis. A change had taken place with antiseptics, but danger had not yet been excluded, and the consideration was laid on the duty in passing the uterine sound, of proceeding with the greatest caution, and of using it as little as possible. It was less used by most gynæcologists since the introduction of the bimanual method. The proper thing to do was to first disinfect the vagina thoroughly. This could not always be carried out in private practice, but in serious cases it was necessary. The sound should be

passed so gently as not to wound. The danger was not less in injecting fluids such as tr. iodi, zinc chloride, etc., and in washing out the uterus. But there were other dangers arising from these, the fatal uterine colic that had so often followed injection into the uterus. The pain came on five to ten minutes after using the injection, it might last for hours. It was not very dangerous, and was cured by a dose of morphine. No means that had been used for avoiding these disagreeable symptoms had had any success. Whether the injection was used cold or warm, whether injected slowly or quickly, was all one. The principal thing was to leave none of the fluid in the uterus. It was useful to withdraw any of the fluid remaining with a syringe. More serious, but also much more rarely, were peritonitic pains after such injections. They did not come on immediately, but frequently only after some hours, and they always began in the neighborhood of one or other tubal opening. Not unfrequently there was fever. The pains continued several days. The speaker had never observed a serious diffuse peritonitis, but such appeared to take place occasionally. The observation of such cases taught us that the peritonitis was without doubt caused by the passage of fluid through the tubes or into the peritoneal cavity. The introduction of instruments and fluid into the uterus might be dangerous in other ways, especially when the tubes were unusually large. Contraction of the tubes might be set up and their infectious contents forced into the abdominal cavity. The application of Playfair's probe was very extensive. For disease of the body of the uterus it was not suitable. It was only exceptionally that the internal os was so widely open that the medicament would not be wiped off before it reached the cavity. It was certainly an advance, therefore, when further form of treatment by Sanger's instrument was invented, consisting of an extraordinarily fine sound of silver which passed through the orifice enveloped in wadding, and by means of its pliability found its own way into the uterine cavity. As regarded artificial dilatation of the uterus, there were only two methods deserving of use, these were laminaria tents and dilatation by means of iodoform gauze packed into the cavity. All others were more or less rejected, and suited only for special cases. Dilatation by means of blunt instruments was not to be practised in the great majority of cases. It presupposed an extraordinary size of the internal os. Where naturally or otherwise the os was so wide that a 6 to 7 mm. sound could pass, it could be increased by these means. Another form was bloody dilatation for the removal of intra-uterine polypi. Here it was advantageous to incise the cervical portion. On the whole, the method of dilating by means of gauze was the best and most suitable. This pro-

cedure was generally considered to be free from danger. The speaker was not of that opinion. He had frequently heard of colleagues who had had an accident with such dilatations. Such cases were not unfrequently met with in literature. He had himself had four cases of undoubted sepsis.

One was a case of broad intra-uterine myoma that was removed. To remove the remnants the uterine cavity was dilated again. This was done by means of relays of iodoform gauze. The temperature rose, and in spite of careful removal of the gauze and washing out, the woman died. This case was not certain, as possibly there might have been iodoform poisoning. In a second case the course was similar, and the patient also died. He had quite recently had two other cases, that fortunately recovered. They were both cases of submucous myoma with thick pedicles. In one case dilatation was performed, a portion of the tumor removed, and iodoform gauze again packed in. The temperature rose to 38° C. The gauze was at once removed, and the cavity washed out with sublimate. In a few hours a rigor occurred and the temperature rose to over 40° C. The only thing that prevented him removing the uterus was that the pulse remained good. A similar case occurred in the clinic at the same time. This patient soon showed grave symptoms that plainly pointed to a form of the most acute sepsis. For this reason twenty hours after removal of the polypus the uterus was extirpated with a favorable result. Shortly after the operation it was shown that the infection had already passed beyond the uterus, for the broad ligaments were already infiltrated. The temperature also showed the same thing. It did not sink to 38° C for four days. In another case the temperature sank at once. These cases might serve as a warning to those who held dilatation by means of iodoform gauze to be free from danger. With all the precautions taken one might ask: How could sepsis take place? Above all, it must not be forgotten that in obstetrics and gynecology one never had pure asepsis. The vagina was never free from germs, and after the introduction of gauze, possibly a passage was opened for them. This procedure was frequently undertaken also when free bleeding was going on. In spite of this, however, the method was indispensable. We should know the danger and use the procedure as little as possible. Dilatation by laminaria was doubtless still more dangerous, and should be used as rarely as possible.

The most important and more dangerous intra-uterine treatment was curettement. No gynecologist would to-day deny that curettement of the uterus was a most beneficial procedure, and many cases could not be successfully treated without it. He was of opinion, however, that it was employed much too frequently. He only knew of

two indications for curettement, a diagnostic a curative. Long continued hæmorrhage and a striking succulence of the mucosa indicated hyperplastic endometritis in which curettement was useful. It was not suitable for catarrh of the cervix as proposed by Sanger. The folds of the arbor vitæ were so small that even the finest instrument could not be got into them. Perforation was one of the dangers of curetting. Especially in puerperity the musculature of the uterus was in a state of fatty degeneration and the walls were so soft that the finger could be poked through. This fact should be borne in mind in passing a sound. This excessive softness of tissue extended far beyond the puerperity. In delayed involution it might last for months. Perforation by means of the curette was not by any means unknown. Five cases were mentioned at the Gynæcological Society's meeting in March last. Symptoms did not usually follow the accident. If they did, opium should be given for a few days, when the patient could be sent home without any harm.

The danger lay in not recognizing the perforation at the time, and scratching round in the abdominal cavity. The results were horrible and generally fatal. How could such an accident be avoided? A steel instrument was dangerous. The most important points as regarded the avoidance of danger in curetting could not be described, they could only be gradually learned. The operator must have a subtle hand and must always bear in mind to be curetting and sounding at the same time, and this can only be learnt by practice. Curetting should not be done by everybody and anybody. Whoever was not accustomed to it had better undertake an amputation of the lower extremity than a curettement. One should bear in mind that gynæcologists in most operations could only work by feel. In his opinion, all perforation of the uterine wall were not blunders, but it was a blunder when the perforation was not noticed and the curette still kept on passing about in the abdominal cavity.—Prof. Olshausen, M.D., in *Med Press*.

CASTRATION IN HYPERTROPHY OF THE PROSTATE GLAND.

When Dr J. William White first suggested to the profession the operation of castration for the relief of hypertrophy of the prostate gland (Address at the Annual Meeting of the American Surgical Association, June 1, 1893, *Annals of Surgery*, August, 1893) on theoretical grounds, although strongly supported by experimental evidence, it is doubtful whether anyone appreciated the full value of the recommendation. Cases of prostatic hypertrophy are of extreme frequency. Sir Henry Thompson found that one man of every

three over 54 years of age examined after death, showed some enlargement of the prostate; one in every seven had some degree of obstruction present; while one in fifteen had sufficient enlargement to demand some form of treatment. In this country to-day, as shown by the last census, there are more than three millions of men over fifty-four; of these, according to Thompson's estimate, which genito-urinary specialists consider a conservative one, about two hundred thousand are sufferers from hypertrophy of this gland. This number seems very large, but the assertions of Thompson unquestionably express a general rule, and in fact every surgeon must have seen men in whom some prostatic overgrowth existed before the fifty-fourth year. The lives of such patients are threatened because, if the obstruction is not removed, the health is rapidly undermined by the retention of urine and the consequent fermentative changes, the deleterious influence of backward pressure on the kidneys, the frequent use of the catheter, and the loss of sleep incident to the incessant demands to void urine. Heretofore the surgeon has been unable to afford distinct relief from the distressing symptoms of an advanced case of this affection. If the patient's general condition would warrant the very considerable risk, some form of prostatectomy was performed. The suprapubic method was recommended for a time, but the difficulties encountered in its performance, the frequency of suprapubic fistula as a sequel, and the high mortality following the operation, have led to its almost total abandonment. Perineal prostatectomy is also attended with considerable risk, on account of the free hæmorrhage, which cannot be controlled during the operation, and the prolonged anaesthesia which is necessary. In addition to this, the operation is a bungling one, in which the enlarged gland is removed by cutting, scraping, or gouging, while the instrument is out of sight, and much of the time it cannot be guided even by the finger. Combined suprapubic and perineal and prostatectomy enables the operator to reach and enucleate the gland with greater freedom, but it is an operation of such gravity that it would be contraindicated in the very cases in which the demand for relief was most urgent.

Perineal prostatectomy is little more than a palliative measure, which does some good, temporarily, by draining the bladder and inducing slight contraction of the middle lobe of the prostate in the healing process. All of these operations confine the patient to bed for several weeks, which is, in itself, objectionable, and in addition requires the use of the bougie for a long time afterwards.

In view of these facts it is not strange that surgeons should have presented Dr. White's suggestion to patients suffering from the consequences of prostatic hypertrophy, nor is it unnatural that such patients accepted this chance for relief from

a condition that in many cases was rapidly and surely impairing the health of a person otherwise vigorous, and, apparently, without this trouble destined to enjoy many additional years of life.

With the testes already or soon to become functionless, and with the contemplation of a long period of intense suffering which will be relieved only by death, sentimental objections pale into insignificance, and the problem of securing relief without placing the life in danger, is the only one entitled to consideration.

Cases of castration based upon Prof. White's deductions, soon began to be reported. Ramu, of Christiania, Norway, recorded two in September, 1893; Haynes, Los Angeles, Cal., and White, Philadelphia, each report three cases; Finney, Baltimore, reports two cases; Smith, St. Augustine, Fla., Powell, London, Mayer and Haenel, Dresden, Moullin, London, Thomas, Pittsburg, Ricketts, Cincinnati, Swain, Bristol, England, and Bereskin, Moscow, each record one case. Thus far eighteen operations have been published. All have been more or less successful, and usually the relief from the distressing symptoms and the shrinking of the prostate have been marvellous. The least favorable cases have experienced infinitely greater relief than has been obtained by any method heretofore employed. At least as many unpublished cases have been operated upon with equally favorable results. There have been no deaths from the operation; of course, few would be expected in the hands of competent surgeons.

To those familiar with these cases, the rapid shrinking of the prostate and the simultaneous relief afforded the patient, have been truly wonderful. The operation has therefore passed the experimental stage, and has legitimately established for itself a position among the most successful of operative procedures. Indeed, the results have been so uniformly favorable, that castration may now be considered a specific for hypertrophy of the prostate.

It is necessary, however, to utter a word of caution here. Castration is not indicated in every case of prostatic enlargement or urinary obstruction. To secure uniformly successful results one must be certain that the condition from which the patient is suffering is appropriate for the operation. Cases of prostatic abscesses, tumors of the prostate and of the region of the neck of the bladder, and other forms of obstruction in the neighborhood of the prostate must be distinguished from true prostatic hypertrophy. Without careful discrimination, both the surgeon and the patient will be disappointed, and the operation will unnecessarily be brought into discredit.

As it stands to-day, however, in appropriate

cases, it appears to mark an advance in the surgery of the prostate, which, when the gravity and the frequency of the condition of hypertrophy are recalled, together with the more or less ineffectual and always dangerous methods of treatment which have prevailed, must be a source of congratulation not only to Professor White but to the profession at large, and to thousands of patients who, having outlived their sexual lives and earned an old age of mental and physical repose and intellectual enjoyment, have had only a few short years of torment and misery to look forward to on account of this hitherto intractable disease.—*Ed. Univ. Med. Mag.*

DIPHTHERIA AND PSEUDO-DIPHTHERIA.

Park and Beebe, *New York Medical Record*, in a report to their chief, Dr. Biggs, of the New York Health Board, record 5611 cases of suspected diphtheria; of these 3255 were found to contain the Loeffler bacilli, in 1540 no diphtheria bacilli were present in the cultures, and as these cultures had been made in an early period of the disease, the cases from which they were taken may be considered as *not* to have been true diphtheria. In 1816 cases, although no diphtheria bacilli were found in the cultures, yet, for various reasons, the cases were considered to be of a doubtful nature, although they were probably not diphtheria. Thus of the 5611 cases of suspected diphtheria, it would probably be just to consider that 60 per cent. were true, and 40 per cent. false diphtheria.

In true diphtheria the ages of the cases attacked range between 3 weeks and 70 years. The number of cases increased with each twelve months of life up to the fourth year, and then gradually diminished. The mortality was highest in the first two years of life, and then steadily diminished until adult life was reached, when it again slowly increased. Scarlet fever was associated with diphtheria in about 5 of every 1000 cases; 450 cases of false diphtheria were investigated, and there were eleven deaths; five of the deaths occurred in children under 5 years of age, and were all laryngeal cases.

Membranous Croup.—In 286 cases examined the disease was confined to the larynx or bronchi, three of these were in adults. In the cultures of 229 of the cases Loeffler's bacilli were found, and they were thus proved to be true diphtheria. In 167 of these 229 cases there was no exudate above the larynx. In 57 of the 286 cases examined no diphtheria bacilli were found, but in 17 of these the cultures were unsatisfactory, leaving 40 cases of croup in which diphtheria bacilli were certainly absent. In 13 of the cases there was more or less exudate on the tonsils or pharynx.

The Value of a Bacteriological Diagnosis.—After a year's trial the following conclusions have been arrived at. The examination by a competent bacteriologist of the bacterial growth in a blood-serum tube, which has been properly inoculated and kept for fourteen hours at the body temperature, can be thoroughly relied on in cases where there is visible membrane in the throat, if the culture is made during the period in which the membrane is forming, and no antiseptic has been lately applied. In cases where the disease is confined to the larynx surprisingly accurate results can be obtained, but in a certain proportion of cases no bacilli will be found from the first examination, and yet will be abundantly present in later ones. In nasal diphtheria a negative result may be obtained from a culture made from the throat, and yet the bacilli be found in cultures made from the nose.

For diagnostic purposes it must be considered that all bacilli found in throat inflammations suspected to be diphtheria, which possess the morphological and cultural characteristics of Loeffler's bacilli, must be considered as virulent unless animal inoculations prove otherwise. Further, it has been shown that the absence of virulence in a culture derived from one bacillus is not sufficient to prove that cultures from other bacilli of the same case would not be virulent.

Length of Time Bacilli Persist in the Throat.—In 605 convalescent cases 304 showed an absence of the bacilli within three days after the complete disappearance of the membrane. In 301 cases the bacilli persisted for a longer time: in 176 cases for 7 days; in 64 cases for 12 days; in 12 cases for 3 weeks; in 4 cases for 4 weeks; in 4 cases for 5 weeks; and in 2 cases for 9 weeks after the time when the exudate had completely disappeared from the upper air-passages.

The Relation of the Pseudo to the True Diphtheria Bacillus.—The authors have examined 330 healthy throats and found eight of the cases to contain characteristic virulent diphtheria bacilli. Twenty-four of the cases contained non-virulent characteristic diphtheria bacilli, and twenty-seven contained non-virulent pseudo-bacilli. They conclude that virulent diphtheria bacilli are to be found in the throats of a small proportion of healthy persons throughout the city, and that they have been derived either directly from diphtheria cases or from those who have been in contact with them. As the bacilli in cases of true diphtheria are known to gradually lose their virulence, and as this loss of virulence can be caused artificially, it seems to the writers that these bacilli, characteristic except as to virulence, should be regarded as true diphtheria bacilli which have lost their virulence. In the twenty-seven cases of pseudo-diphtheria there were differences in staining, etc.,

which give abundant reason to separate them from true bacilli.

Virulent bacilli may be received (1) from discharges and membranes from diphtheria patients. (2) From the secretions of the throat and nose of convalescent cases in which the bacilli persist. (3) From the throats of healthy individuals who have acquired the bacilli by being in contact with others having virulent germs on their persons or clothing.

The conclusions reached by the authors are here appended. They seem justified by the article of which the above is a very brief abstract. The article is worthy of very careful reading by all physicians.

(1) All inflammations of the mucous membrane due to the diphtheria bacillus of Loeffler should be included under the name diphtheria, and in this report they have been so included. An acute hyperæmia of the mucous membrane, caused by the Loeffler bacilli, is considered as truly diphtheritic as an inflammation with pseudo-membrane or exudate, and a case in which the lesions are confined to the larynx or bronchi as truly diphtheria as one in which the tonsils and pharynx are involved.

(2) Under pseudo-diphtheria should be included all inflammations of the mucous membranes which simulate true diphtheria and which are due to streptococci, or, more rarely, cocci.

(3) The name croup, or membranous croup, should be regarded as a term merely indicating that the location of the pseudo-membranous or exudative lesion is in the larynx, and not as describing the nature of the disease, whether diphtheritic or pseudo-diphtheritic. In New York City, at the present time, 80 per cent. of the cases of "croup" are diphtheria.

(4) The examination of cultures made upon solidified blood-serum under the conditions insisted on by the department form a reliable method for determining whether the diphtheria bacillus is present or absent in a throat. For diagnostic purposes cultures should be made before the pseudo-membrane or exudate begins to disappear.

(5) Virulent diphtheria bacilli were apparently present in about 1 per cent. of the healthy throats in New York City at the time of these examinations. Diphtheria was, however, rather prevalent at this time. Most of the persons in whose throats they existed had been in direct contact with cases of diphtheria. Very many of those whose throats contain the virulent bacilli never develop diphtheria. We must, therefore, conclude that the members of a household in which a case of diphtheria exists should be regarded as sources of danger, unless cultures from their throats show the absence of virulent diphtheria bacilli.

(6) The bacilli found in the original serum cultures which in appearance and staining are identi-

cal with the typical Loeffler bacillus may be regarded for diagnostic purposes as virulent diphtheria bacilli, if the cultures have been made either from throats containing exudate, or from those of persons who have been in contact with true diphtheria; for investigation has shown that over 95 per cent. of such bacilli are virulent. Bacilli, on the other hand, which resemble the pseudo-diphtheria type must be subjected to both cultural and animal experiments before their nature or virulence can be judged.

(7) All bacilli which are identical with the virulent Loeffler diphtheria bacillus, morphologically, biologically, and in staining by re-agents, should be classed with the diphtheria bacilli, whether they have much, little, or no virulence when tested on guinea-pigs. Bacilli which have entirely lost their virulence rarely, if ever, regain it. They probably are incapable of causing diphtheria, for the twenty-four cases in which they were found by us never developed any lesions, nor were they the origin of any case of diphtheria, so far as could be ascertained.

(8) The name pseudo-diphtheria bacillus should be regarded as applying to those bacilli found in the throat which, though resembling the diphtheria bacilli in many respects, yet differ constantly in others equally important. These bacilli are rather short, and are more uniform in size and shape than the typical Loeffler bacillus. They stain equally throughout with the alkaline methyl-blue solution, and produce alkali in their growths in bouillon. They are found in about 1 per cent. of the healthy throats in New York City, and seem to have no connection with diphtheria. They are never virulent.

(9) One or more varieties both of streptococci and of other forms of cocci exist in the great majority, and possibly in all, of the healthy throats in New York City. Cultures from the throat in cases of pseudo-diphtheria contain more cocci, especially more streptococci, than those from healthy throats, but otherwise do not seem to differ.

(10) The investigations of the health department have given striking evidence of the marked difference in mortality between true and pseudo-diphtheria, for while it was 27 per cent. in diphtheria, it was under 2 per cent. in pseudo-diphtheria.

(11) The combined clinical and bacteriological investigation of over 5,000 cases has demonstrated clearly the fact that many of the less characteristic cases of diphtheria are so similar in appearance, symptoms, and duration that it is impossible to separate them, except by bacteriological examinations. In the more severe cases, and after the disease has fully developed, cultures are less necessary, although their systematic use is desirable.

(12) Persons who have suffered from diphtheria

should be kept isolated until cultures prove the bacilli have disappeared from the throat, for, not only are the bacilli which persist in the throat virulent, but they are not infrequently the cause of diphtheria in others. Where cultures cannot be made, isolation should be continued for at least three weeks after the disappearance of the membranes, for our experience has shown that it is not unusual for the bacilli to persist that length of time.

(13) In pharyngeal cases in which thorough irrigation of the nostrils and throat with 1 to 4000 bichloride of mercury solution has been practised every few hours, the bacilli have not remained in the throat for as long a time after the complete disappearance of the pseudo-membrane as when no antiseptic has been employed. Other antiseptic and cleansing solutions may also be useful.

(14) Inflammations of the mucous membrane due to streptococci, either alone or associated with other cocci, are usually mild in character. These inflammations may be more serious when the lesion is located in the larynx, or when they are complicated by scarlet fever or measles.

(15) While the streptococci, and perhaps other forms of cocci, may be considered as the primary etiological factor in pseudo-diphtheria, yet, in the majority of cases at least, certain predisposing factors, such as exposure to cold or other deleterious influences, or the presence of certain infectious diseases, appear to be of great importance in determining the occurrence of the disease. The streptococci which, under these conditions, apparently cause the disease are probably those which had for a long time existed in the throat, and not those freshly derived by communication with other cases of pseudo-diphtheria. In a small number of cases, indeed, the histories suggest a direct communication, but the causation may be equally explained by the supposition that the second case shared with the original one the same predisposing cause.

(16) The slight mortality and the usual mildness of the cases of pseudo-diphtheria do not warrant us in enforcing isolation, even if further investigation produced positive proof that this disease is communicable. With the results of these investigations before us we can appreciate the difficulty of exterminating diphtheria from a city like New York. On the one hand, we have cases of diphtheria scattered all through the city, many of which are so mild as to be unrecognized, and, on the other hand, we have the crowded tenements with their ignorant and shifting population, where proper isolation of the patient from other members of the family, or of the family from other inmates of the building, is usually impossible, unless harsher measures are adopted than are now customary.—*Univ. Med. Mag.*

NON-OPERATIVE TREATMENT OF HÆMORRHOIDS.

Gibbs, who writes on this subject in the *Post-Graduate*, makes no distinction between the two common varieties of piles—the internal and external—because the treatment of either answers for the other. There is a very painful little tumor frequently seen on the verge of the anus, very much the size and color of a huckleberry, consisting of a small thrombus in one of the marginal veins, covered partly with skin and partly with mucous membrane. If let alone, the clot is absorbed and the tumor disappears, or else becomes infected, suppurates, and cures itself spontaneously; but in either case only after, perhaps, a week of suffering. In these cases the proper plan—and few patients will object—is to use a few drops of cocaine, laying open the cavity and pressing out the entire clot, thus curing the trouble and stopping the pain in half an hour or less. If, on the other hand, this little operation is not permissible, there is nothing to do but undertake three or four days' treatment, based on general principles, consisting in cathartics, preferably podophyllin or cascara, rest in bed, and cold or hot applications. Cocaine he has not found always satisfactory, though it does sometimes work to a charm. Among the wet applications, either hot or cold, his preference is for some preparation of witch hazel or the common hospital lead and opium.

Last, and not least, is the time-honored suppository of opium and belladonna, so dear to the hearts of the medical profession. This is the recognized hospital treatment in New York, and covers all cases of pain from any cause whatsoever, when the lesion is low down, in reach of the anus, but in severe cases rest in bed with catharsis accomplishes far more in a given time.

More painful still, and more difficult to handle, is that complication of marginal hæmorrhoids known as fissure. It is most usually found posteriorly in the median line, overlapped by a fold of protruding hæmorrhoid. Here again, comes up the question of operation. For the most part when the writer finds a case of this sort that does not respond to the general treatment just laid down, he strongly advises giving ether, stretching the sphincter, cutting the fissure, and removing the hæmorrhoids, thus radically curing at once an old chronic disease. Next best is the treatment already mentioned, when enforced as vigorously as possible.

Not infrequently these fissures heal quickly under local applications of nitrate of silver not stronger than 20 grains to 1 ounce, repeated not oftener than once in twenty-four hours; while, on the other hand, the solid stick is very apt to

convert a small tear in the mucous membrane of the anus into a chronic, intractable ulcer. The temptation to use morphine in very severe, prolonged pain is great, yet the harm it does in these cases is not to be forgotten. Admitting the truth that constipation is the direct cause of acute symptoms in chronic rectal diseases, we have no doubt in saying that a three or four days' course of morphine will reconcile almost any patient, no matter how timid, to either death or operation, after the first passage over an "intolerable" fissure. Verily, "constipation is the thief of time." A less frequent cause of pain, as a symptom of piles, may be seen when a mass of tumors prolapses and remains outside of the body, swollen, red and perhaps gangrenous. Here the same procrastinating treatment will, in a week, more or less, help to diminish the acute symptoms. To summarize: In order of importance, rest in bed, unloading of the bowels, sensible diet, abstinence from alcohol, and an abiding faith on the part of the medical attendant that subsequent and severe attacks will induce a great sufferer to submit to an operation involving no pain or risk to life, with a guarantee of no more trouble.

The second symptom already spoken of is hæmorrhage, usually accompanying the act of defecation, and varying from a few drops to an ounce or more. Most people do not bother with "a little thing like this," simply because it entails no pain.

On the first occurrence of bleeding, many patients are more or less frightened, until they have assured themselves that they have "nothing but piles," and let it run on indefinitely, except in those rare cases when the loss of blood begins to reach the point of exsanguination; but the majority of cases are allowed to continue or stop spontaneously. Hæmorrhage, whether profuse or not, can be easily controlled, if the bleeding spots or area can be seen, by careful applications of nitric acid, or by touching with the Paquelin or galvano-cautery. There is no pain unless the skin margin is burned, and one application should be sufficient. Of course, any destruction of healthy mucous membrane does harm, and the cauterization should be superficial and limited to the bleeding points or areas. Such cases as require etherization and ligation the author has read of, but not seen.

Prolapse of internal hæmorrhoids occurs in advanced cases where the tumors are large and flabby. Whether they return to the cavity of the rectum with or without assistance after defecation, this symptom causes but trifling annoyance. It is not till the sphincter becomes somewhat relaxed and allows protrusion at any time, on standing or walking, that any real distress occurs, and this brings us back again to the subject of pain and what to do for it. In these severe cases

local treatment is not very promising. Local applications or cauterization, thorough reduction, and laxatives are worth trying, especially if reinforced by a few days' rest in bed. If these fail, there is nothing but operation. Last and worst of all are cases of prolapsed hæmorrhoids that refuse to be returned, become gangrenous, inflamed and extremely painful. There is then absolutely nothing to do but rely on the cure and wait for the sloughing to destroy enough tissue to allow retraction and contraction.

The general principles already laid down are to be applied in the many nervous reflexes so common to all rectal diseases: symptoms referred to the bladder, urethra, ovaries, intestinal tract. After successfully quieting one or all of the symptoms of which we have spoken in such detail, there is nothing so useful as a local tonic as cold water applied to the perineum twice a day with a bath sponge; better than any suppository or astringent, used copiously, not inside the rectum, but outside of it. We have omitted all mention of carbolic acid injections, for the reason that this method of treatment is in its true sense a surgical operation devised for the purpose of doing away with venous tumors, and liable to all the dangers and complications of cutting with knife and scissors, such as great pain, infection, abscess, sloughing to any extent, and secondary hæmorrhage. Were we discussing operative measures it would have to take its chance with the ligature, the clamp and the cautery. Summing up in a few words, the non-operative treatment of hæmorrhoids comes down to general medication of some predisposing cause and local applications to relieve individual symptoms.—*Therapeutic Gazette.*

"THE INCREASING NERVOUSNESS OF OUR TIME."

Under this rather startling title Professor W. Erb at Heidelberg gave an address some time ago which demands more than a passing notice. Professor Erb takes it for granted that there is marked increase of functional nervous disorders, and he believes that the events of the present century have naturally led to this result. The nineteenth century began in disorder and commotion. France had passed through a bloody revolution which was to be followed by the excitement and exhaustion of Napoleonic adventures; restlessness, political and social, was followed by a period of calm, but, with the advancing years, labor-saving inventions rapidly replaced man and increased wealth, and rendered communication easy—as our author says, time and space seemed to be annihilated.

In science, in literature, all were developing, and with it there appeared incapacity for restful

pleasures; rushing from change to change seeming to be the only alternative to work. With overwork there was over-crowding and over-stimulation; alcohol and tobacco were used in greatly-increased quantities; railway travelling and its nerve-jarring motion still further tended to nervousness; and, so Professor Erb convinces himself, that with all this there has been a clear loss of nerve tone to the whole of the highly-civilized nations.

Nothing could have been more brilliantly put than the contrast between the normal reaction to work and worry and the neurasthenic and abnormal reaction to the same conditions, and it will be for us to see whether we agree with all that Professor Erb says. According to him, all this rapid restless movement has left an irritable and slow-recovering nervous system, which must be considered as neurasthenic. The essentials of this disorder, which has not been recognized twenty years, are increased sensitiveness, with weakness, weariness, lack of power of endurance, and defective recuperative power. This disorder is a refinement of hysteria and hypochondriasis, and it is the outcome of the conditions of life. He thinks it ought to be found in all periods of excitement and of luxury, but owns that there is no evidence of its existence in Greece or in Rome.

The disorder is to be recognized and to be met by changing conditions, and nerve hygiene is to be considered as much as sanitation. From school days to professional life the human being is to be tended and brought up, his mental, moral, and physical education is to be regulated, his holidays are to be methodised, his business is to be conducted in healthy surroundings, and his cities are to be made healthy and beautiful, with fresh air and beautiful surroundings. Thus the Professor is a preacher of hygienic socialism. As we said before, we have been charmed with the address, but not convinced.

The old question reappears in another form. Is increased insanity and nervous disorder in necessary correlation to developing complexity of society? It must be recognized that the more complex the rules of society the more frequent will be breaches of these rules, at all events, for a time. In developing civilization, too, we have a very perplexing factor added in the survival and the propagation of the non-fittest, and this doubtless adds to the increasing number of the nervous.

We are inclined to believe that there is some slight increase of nervousness, but that there is a much greater knowledge of the subject, and with knowledge comes sub-division and classification. We remember the time when hysteria, in its present connotation, was looked upon as a new and increasing danger to society. This disorder is now recognized as no longer a defect of will for which the patient is to be blamed, and has been

sub-divided. Hypochondriasis in the same way is no longer considered to be a *maladie imaginaire*, but is recognized as having some organic basis, and with this progress the so called functional disorders have to be studied apart, and are now placed under the head neurasthenia. We do not believe more women, at all events in England, have "nerves" now than had fifty years ago. With the increase of excitement there has been a still greater tendency to more freedom of exercise, more freedom from conventionalism, and much healthier home surroundings.

One change to which attention might be called is the decrease of religious feeling and the allied emotional excitement. It is thought by our author that over brain-work has had a very serious effect. We have grave doubts as to overwork being established as a cause of neuroses, and we have still greater doubt as to there being any amount of overwork in England. Worry, not work, is the danger, and we believe that danger arises from decreasing and deferred marriage.

We agree with our author in recommending carefully selected mates, and healthy surroundings, and skilled and orderly education, but we do not believe that people will be made good by Acts of Parliament or professional orations, and we do not believe there is any very serious risk to the stability of society in the so-called development of neurasthenia.—*Br. Med. Jour.*

THE EFFECT OF THE LOCAL APPLICATION OF GUAIACOL IN THE REDUCTION OF THE TEMPERATURE IN TYPHOID FEVER.

In a conversation I had last spring with Dr. J Solis-Cohen regarding a case of pulmonary tuberculosis with a high temperature, he suggested the use of guaiacol locally applied for its reduction as a remedy that had proved useful in his hands.

When I entered upon my term of service as attending physician to the Williamsport Hospital, the first of September last, I determined to give this remedy a good fair trial in the reduction of temperature in typhoid fever. I had it applied 230 times in the hospital and 43 times in private cases, making 273 times it was applied under my direction in three months. These applications were made to 12 different persons, 7 males and 5 females, making an average of about 24 applications to each person. The greatest number of times it was applied to any one person was 70, and the least number of times it was applied was once; the largest dose used was 25 drops, and the smallest dose used was 2 drops; the greatest reduction of temperature was from 106.8° to 101°

by the application of five drops, in the case of Mrs. Horton, with a corresponding reduction of the pulse from 136 to 110 per minute. Again you will notice in the same case, by applying 5 drops on the same day when the temperature was 106.2°, with a pulse of 148, it was reduced in one hour to 102°, and the pulse to 120 per minute. This patient, as you may see by consulting the special reports, was unusually susceptible to the action of this drug, as the application of 2 drops when the temperature was 103° and the pulse 130, in one hour and thirty minutes reduced the temperature to 101.4° and the pulse to 120, while in the case of James Hill 20 drops were required to reduce the temperature from 104° to 98.4° in three hours and fifteen minutes.

I show you a large number of special reports of the cases in which guaiacol was applied, and which may be useful in showing not only its effect on the temperature, but also the effect on the pulse and respiration. You will observe that within thirty minutes after the application there was a fall in the temperature, and in most cases there was a corresponding reduction in the number of heart-pulsations per minute. The method of application was as follows:

The right iliac region was thoroughly cleansed with soap and water, and, after being dried, the guaiacol was slowly dropped upon the part and thoroughly rubbed in with the hand for from ten to fifteen minutes. The part was then covered with oiled silk. The only preparation used was that prepared by Merck, and it did not fail in a single instance to produce the desired result. Any other point would probably be as good for its application, but as it was as near the seat of the disease as I could possibly get, and the ease with which it could be reached and covered with the oiled silk without in any way disturbing the patient, made me select this point for its use.

The effect of guaiacol lasts from three to four hours, and the more often it is used the greater the effect. I observed a number of chills from the sudden reduction of temperature, but after I became more accustomed to its use the chills were much less frequent. If it can be avoided, the temperature should not be reduced below 100°, which can easily be regulated after the applications have been made a few times, care being taken to commence with a small dose, say 10 or 15 drops. I have never found it necessary to use the large doses of 40 or 60 drops as employed by Dr. DaCosta.

It has been suggested that by this rapid reduction of temperature there is danger of producing congestion of some of the internal organs of the body. I have not seen a single unfavorable symptom (except the occasional chill) follow its use.

All of my cases recovered. There was but one case of pneumonia-complication, and this could in

no way be attributed to the guaiacol, as it came on six days after the last application had been made. Sweating nearly always followed the application, being more severe when the reduction of temperature was sudden than when it was more gradual. No marked depression followed; the pulse was lessened in frequency and decidedly improved in strength.

No irritation of the skin followed when the guaiacol was used alone, and patients never objected to its use. The disagreeable odor that has been described by some as being objectionable to patients was never referred to but by one, and then only on the first application.

I used guaiacol and eucalyptol combined in the proportion of one of the former to two of the latter a number of times, but believe I had better results with the guaiacol alone. Besides, eucalyptol produces decided irritation of the skin, and in no way adds to the efficacy of the guaiacol.

This drug when applied to a person having a normal temperature produces no effect either upon the general condition of the individual or upon his temperature, as shown by an appended chart.

When I was following these investigations I had no knowledge of guaiacol having been used locally for the reduction of temperature in typhoid fever, but on looking over the literature of the subject I found that Dr. DaCosta used it in a few cases in the Pennsylvania Hospital last spring.

It is asserted by therapists that guaiacol is eliminated by the lungs and kidneys. In my cases treated with it repeated examinations of the urine were made by the resident physician, with negative results so far as the finding of the drug was concerned. It was at times noticeable on the breath.

In the carrying on of these investigations I received material aid from Dr. H. C. Frontz, resident physician, to whom I wish to return my thanks.

In summing up this question I feel convinced of the following facts:

1. That guaiacol when locally applied is certain to reduce temperature.
2. That with the care that a physician should always use in the administration of drugs, it is absolutely safe.
3. That chills will not occur if the temperature is not reduced below 100° Fahrenheit.
4. That no deleterious effect is produced upon any of the organs by its use.
5. That it is easy to apply, and can be used by anyone competent to nurse a typhoid fever case.
6. There are no depressing effects following an intelligent use of the drug.
7. That by continued use the dose can be gradually lessened.
8. That it is far superior to the cold bath; that it can be used by one person; that no appliances

are necessary for its use that are not obtainable in every house; that it is much more pleasant to the patient; that it is fully as effective; that patients are not subjected to the danger of moving, and they offer no resistance to its use.

I have thoroughly tried the bath and cold packs, and I know they have proved very efficacious in many cases, but with my experience with guaiacol I have no desire to return to either of them.—Dr. McCormack in *Med. News*.

CHLORAL IN LABOR—The use of chloral in the earlier stages of labor is undoubtedly gaining favor in this country. We understand that it is largely used in England. Dr. Gardiner has recently written strongly in its favor in the *Lancet*. He believes that it has a marked power in assisting dilatation of a rigid cervix and has never seen post-partum hæmorrhage following its use. Playfair has long been an advocate of the drug for this purpose. In the last addition of his work on obstetrics he is even more positive in his statements than in his former editions. Those who have had much experience, will, we think, agree in this opinion. Playfair expresses the belief that it is destined to be more extensively used than is at present the case. In his English edition he says that so far as his experience has gone, he has not met with any symptoms which has led him to think that it has produced bad results.

The point of special value in favor of chloral is that it may be administered when chloroform cannot be used. To many mothers the most distressing part of the labor is the early stage when the pains are nagging and ineffectual. While the pains are cutting and grinding during the early stage of dilatation, chloroform can rarely be used, but chloral frequently gives most satisfactory relief. Especially among nervous mothers of the upper classes, these pains are sometimes almost intolerably severe, while the labor progresses but little. After the use of chloral, we have repeatedly seen a despondent and anxious mother regain her courage and pass through her ordeal with comparative ease. It unquestionably relieves the irregular and nagging pains of this stage, and it is our belief that it materially aids in dilatation of a thin and rigid cervix. Playfair believes that nothing else answers so well in case of rigid or undilatable cervix and believes it is a most effective remedy in such conditions.

The amount of chloral administered must vary with the case and conditions. Fifteen grains may be given at the first dose, and may be repeated in half an hour, and again, if necessary, after one or two hours. If the stomach is irritable and will not retain the chloral it may be given by rectal injection. It seems in fact to be even more effec-

tive when administered in this way. Thirty grains are usually sufficient to produce a somnolent condition in which the pains become less frequent but stronger, and in which nervous excitement is calmed. The patient frequently drops into a light sleep between the pains, but rouses as soon as they recur.

The use of chloral does not in any way interfere with the use of chloroform. The use of chloroform, however, is not required so early and the amount administered as a rule can be much less. We are convinced that too free use of chloroform retards the pains and that the tendency to post-partum hæmorrhage is somewhat increased. We have not seen this after the use of chloral.

The time is long since past when arguments are required to establish the propriety of administering anæsthetics during the course of labor. It is the duty of the physician not only to cure disease, but to relieve pain and suffering. The physician who neglects to relieve suffering when he can do so without detriment to his patient is seriously remiss in his duty.—*Gaillard's Med. Jour.*

THE PATHOLOGY OF THE PROSTATE.—The theories current at present regarding this condition (hypertrophy) are: 1. That based upon the analogy between it and fibroid disease of the uterus. 2. That it is merely an occurrence in a constitutional disorder which begins as an arterio-sclerosis and ends in fibroid degeneration, affecting the genito-urinary organs in a special manner. 3. That it is secondary to and developed as a compensatory measure to primary changes in the bladder.

These three theories are disproved by the following facts: 1. The prostate is not the homologue of the uterus. 2. Uterine growths originate as fibromyomata and have little or nothing to do with the mucous membrane; neither does the enlargement begin as a fibroid degeneration, but as aglandular overgrowth. 3. The prostate is of sexual origin and has to deal only with sexual function. It has nothing to do with micturition, which, if the prostate remains undeveloped or undergoes atrophy, takes place just as if the prostate were normal. There are, however, certain facts which we know that suggest the real cause. The enlargement is dependent in some way upon the testes. The evidence in favor of this is in brief as follows: 1. The normal development of the prostate is undoubtedly controlled by that of the testes. Up to puberty there is no prostate worth mentioning. 2. If castration is performed before puberty the prostate never grows; if after puberty, it wastes and disappears, and the same has now been shown to be true of the abnormal development known as enlargement. This rarely begins after an age at which it may be presumed that the testes are no longer functional, and it disappears if they are removed. There are now nine

cases on record in which castration has been followed by a complete disappearance of the enlargement within a few weeks. How the testes act is questionable. The mere induction of sterility (such as by section of the vas deferens), although it may cause atrophy of the testes, does not appear to be sufficient. The influence, whatever it is, comes from the testes themselves and exists so long as they are present. It may be exerted through the nervous system or through the circulation. Three cases have lately been reported of unilateral atrophy after removal of one testicle. If post-mortem examination of these cases should show this to be true, it is probable that the influence is exerted through the nervous system.

If this suggestion that enlargement of the prostate is dependent upon some change which takes place in the testes during the latter part of their active life, should be accepted, it will be a curious instance of the way in which modern views are sometimes foreshadowed by the speculative theories of a long past date.—*Lancet.*

THE TREATMENT OF CYSTITIS.—Dr. Gardner W. Allen, of Boston, read a paper on this subject, based on the records of a number of cases which had come under his observation during the past eight years. Many of these cases had been of gonorrhœal origin, and in nearly all the inflammation had been confined to the neck of the bladder. Extension of gonorrhœa into the neck of the bladder, accompanied by a sharp onset of urinary symptoms, was, of course, common enough. In non-gonorrhœal cases the cause of the cystitis was not always clear, but in a certain number the disease was apparently traceable to a posterior urethral catarrh resulting from congestion of the prostatic portion, with or without inflammation of the seminal vesicles, and brought about by prolonged and repeated sexual excitement. It began insidiously, had little or no tendency to recovery, and was apt to prove intractable to treatment.

As regarded the treatment of cystitis, of the various internal remedies the author said that he preferred the saline diuretics, especially benzoate of sodium. Few surgeons nowadays, however, long deferred local treatment of the disease. For the simple purpose of washing out the bladder, perhaps a saturated solution of boric acid gave, on the whole, the best results. For the purpose of producing a decided impression upon the mucous membrane of the vesical neck the author said that he had had very gratifying experience with nitrate of silver and permanganate of potassium. Of the nitrate of silver, he rarely used it stronger than in one-per-cent. solution, injecting from ten to fifteen minims. The injections appeared to be more effectual if preceded immediately by the passage of a large sound, excepting in the more

acute cases. Permanganate of potassium he had found to be very efficacious in cystitis and chronic prostatitis. Where it failed nitrate of silver often succeeded, and *vice versa*. The bladder should be thoroughly irrigated with the permanganate solution (1 to 4,000 or 1 to 5,000), and this was conveniently done by means of a large Uitzmann syringe connected with a soft-rubber catheter. One syringeful at a time was injected and allowed to flow out again, and this was repeated until the solution came away with its color unchanged. Then two or three ounces were injected and left in the bladder as long as they could be comfortably borne. The author then detailed the histories of a number of cases of cystitis, that had come under his observation.—*N. Y. Med. Jour.*

A NEW METHOD OF REDUCING BACKWARD DISPLACEMENTS OF THE UTERUS.—Reporting the communication of Rapin at the Rome Congress, Batnaud says that many cases of backward displacement of the uterus, in which this organ is supposed to be adherent to the surrounding viscera, are, as a matter of fact, simply held in Douglas' pouch by a combination of atmospheric pressure, the intestines, and the two layers of the sacro-uterine ligament, which imprison it laterally. To dislodge the uterus from this incarcerated position, Rapin has proposed this procedure:

The first two times insert the sound and rotate in the usual way. If the position remains unchanged, the third time, instead of lowering the handle of the sound, press upon the sound from behind forward and from below upward, moving the uterus as with a lever; by so doing one presses upon the entire anterior face of the uterine cavity, not only with the point, but with the entire part of the sound within the uterus; then we raise and draw the uterus forward and upward without endeavoring at first to replace it.

By this manœuvre we dislodge the fundus from the rectum, opening the *cul-de-sac*, and the intestines, pressed down by the atmospheric pressure, fall into the place formerly occupied by the fundus, thus aiding in the forward movement of the organ.

At the moment the intestines assume their new position one feels that the resistance is overcome, and if now the handle of the sound is lowered, the replacement is completed without the aid of force or the provoking of pain. The sound is withdrawn, while, with the index finger in the vagina, the neck of the uterus is pushed backward and the fundus comes forward into position. When there is resistance to the upward and forward traction, instead of the continuous pressure, a to-and-fro or a sawing movement, causing the uterus to advance in a zigzag manner, is often of advantage.

In all these manipulations the sound is governed by one hand, while the index finger is placed within the vagina, palpating the *cul-de-sac* and controlling the sound within the uterus.

To maintain the uterus in position a pessary is used that fits partly in the vagina and partly within the uterine cavity.—Jules Batnaud, in *Revue Médico-Chirurgicale des Maladies des Femmes*—*The Brooklyn Medical Journal.*

A NEW AND RELIABLE ANTHELMINTIC.—Dr. Mirowicz first called public attention to naphthaline, as a reliable anthelmintic and tenicide, in 1891. Naphthaline is a coal-tar derivative, crystalline in form, insoluble in water, and but slightly soluble in alcohol. It is soluble in alkaline digestive fluids, but is not absorbed through the intestinal walls to any appreciable extent. Four hours after the exhibition of a maximum dose, no evidence of its presence could be detected by any abnormal products in the urine or sweat. It is absolutely destructive to all forms of entozoa, is an unchangeable intestinal antiseptic, is a neutralizer of ptomaines—rendering them innocuous, is an anti-ferment. As a tenicide, one dose is usually sufficient, and it is unnecessary to examine for the head—it always comes away. There is no uncertainty about the dose, as with *felix mas*; there is no permanent injury to the gastric glands, as with tannate of pelletierine; there is no terrible cephalalgia, as with ammonium embelate; there is no danger, as with chloroform.

Naphthaline, however, has its drawbacks. It is a very disagreeable drug to administer. Not only is it quite unpleasant to the taste and smell, but it is followed by offensive eructations.

As to technique, it should be given in capsules, 20 grains for one dose, and in the morning when the stomach is empty.

The three previous meals should contain an excess of salty and vegetable acid foods. Four hours after taking the capsules, an 8 grain dose of calomel with 4 grains of bi-carbonate of soda should be given, followed in another four hours by two tablespoonfuls of castor oil. This is for an adult of average size. The dose for children should be about one-half as much, given only when extreme debility does not exist. Naphthaline can be had from any first-class drug house and should cost about 20 cents per ounce. The chemically pure crystals only should be used.—A. D. Hurd, M.D., in *The Cincinnati Medical Journal*

LYCETOL.—Dr. Wittzack, (*Allg. Nedivn. Central Zig.*) calls attention to this new derivative of piperazine, which has been introduced by the *Farbenfabriken vorn. Friedr. Bayer & Co.*, of Elberfeld. Lycetol is the tartrate of dimethyl piperazine and is fully as effective as the base piper-

azine. Aside from the pronounced action of the base as a uric acid solvent, a favorable effect could be anticipated from this preparation because the other component consists of tartaric acid (*i. e.*, an alkaline tartrate) which has a prompt diuretic action, and also for the reason that the tartrate is converted into a carbonate in the organism and renders the blood alkaline. If the theory is correct that in gout in general, there is no increased formation of uric acid, but that the blood of gouty persons is only faintly alkaline, and therefore less capable of holding uric acid or its salts in solution, then the administration of this tartrate of a piperazine derivative, must produce the combined effects of its components. Lycetol also possesses the great advantage of having an excellent taste and of being non-hygroscopic. Its aqueous solution has an agreeable acid taste and if some sugar be added it is cooling like lemonade, and does not excite repugnance when administered for a long time. On account of its freedom from hygroscopic properties it can be dispensed in the form of powders. Wittzack has employed lycetol in seven cases of uric acid diathesis with excellent results. After its administration he observed: 1. A considerable increase in the secretion of urine. 2. That the remedy was well tolerated without producing any disturbance of the general health. 3. A subsidence of the gouty symptoms, an absence of the otherwise periodical recurrence of gout and a considerable diminution of urinary gravel under its continued use.

THYROID EXTRACT IN GOITRE.—The author states that his observations confirm the excellent effects (previously reported by others) of the ingestion of thyroïdin on ordinary goitre patients. Of 12 patients thus treated, 9 were cured, or at least improved.

In all these cases use was made of an extract of raw thyroid gland (from the sheep or calf), administered in cachets or sandwiches, in doses of 6 to 10 grammes ($1\frac{1}{4}$ to $2\frac{1}{2}$ drs.), repeated at intervals of 2 to 8 days.

Among the author's patients were four children, from 4 to 12 years old; in all of these, after 8 to 15 days, there was a considerable diminution in the size of the tumor; in four weeks the goitre was entirely gone. In the fifth case—a goitre with a cyst—the ingestion of thyroid extract caused the complete disappearance of the parenchymatous part of the tumor; the cyst, however, resisted the treatment. With this patient, the circumference of the neck decreased 7 cm. (say 3 inches).

The sixth case concerned a man who had been afflicted since 6 years with a goitre of the size of a child's fist, on the right side of the neck, and causing a displacement of the trachea and an obstruction to respiration. After four weeks'

treatment, the respiratory disturbances ceased; the swollen lobe of the thyroid resumed its normal consistence and dimensions, and the circumference of the neck had diminished 5 cm. (2 inches).

Finally, with three other patients, goitres as large as an orange diminished in size under the ingestion of thyroid extract.

The three cases not benefited by this treatment had already reached the stage of cystic or colloid degeneration when they came under this treatment. The remedy, it is said, was always well supported, excepting in one case.

The author thinks that the phenomena of intoxication may be avoided by administering the thyroid extract once every 8 to 10 days only, and in doses not exceeding 10 grammes ($2\frac{1}{2}$ drs.) for adults and 5 grammes ($1\frac{1}{4}$ drs.) for children.—Dr. P. Burns, in *Sem. Med.; Am. Med.-Surg. Bull.*

AUTO-INTOXICATION.—S. Schwalbe (*Real-Encyclopädie d. ges. Heilkunde*, Bd. iv. 1894,) after referring to the investigations of v. Jaksch and Kobert states that auto-intoxication includes every poisoning of the body in which the poison as such is not introduced from without. There are retention and noso-toxicoses, the latter being subdivided, as they are, or are not, produced through microbial agency. Recently the opinion is gaining ground that the toxic effects are often due to the poisonous substances in the bacteria themselves. Among the retention toxicoses the author speaks of Bouchard's investigations into the toxic action of the urine and alludes to the view that this is due to potassium salts. The exact cause of uræmia is still unknown. The alimentary canal is a further source of retention toxicoses. Intestinal peristalsis must be interfered with, and the contents should be fluid. Catarrhal jaundice belongs to the same group. The causes of cholæmia are multiple. It may also possibly be produced by the absorption of poisonous products from the intestine. Neither experimental extirpation of the thyroid gland nor the brilliant results of thyroid feeding prove that myxædema is necessarily a mucinæmia. Glykæmia stands in the same relation to the pancreas as mucinæmia is supposed to do to the thyroid. Gout is a toxicosis or uratæmia. Cyanosis and severe cerebral symptoms are the expression of auto-intoxication from the respiratory tract. An auto-intoxication due to suppressed insensible perspiration has not been proved to exist. The noso-toxicoses are, according to many, the auto-intoxications strictly so-called. These consist in acids, gases, ptomaines, leucomaines, tox-albumens, enzymes. The source of most poisonous metabolic products lies in albumen. (The specific products of micro-organisms are not included in this article.) Migraine and tetany

probably depend on auto-intoxication from the alimentary canal. The author gives some details of ammoniæmia, hydrothionæmia, acetonæmia, and the intoxication due to the organic acids, and refers to the excretion of poisonous products by the urine in acute and chronic diseases.—*Br. Med. Jour.*

THE DIET OF EPILEPTICS.—The influence of diet upon epilepsy is a matter of peculiar importance in the treatment of the disease. In a certain sense epilepsy is always reflex. The starting point of a fit must be looked on as an extrinsic irritation, and in many cases it arises from indigestion. Errors in diet, however, probably influence epilepsy in other ways than this. The portion of food which is absorbed may be injurious, besides that which, remaining undigested, acts as an irritant, and there is a good deal of clinical experience in favor of supplying a minimum quantity of meat in cases of this sort, not on account of it producing indigestion, for it is often digested quite well, but because of its imagined effect in increasing the "irritability" of the nervous structures—a somewhat hypothetical property, but one based on the same sort of rough observation as is the well-recognized relation between corn and skittishness in horses. The interest of this subject has led us to make inquiries as to the food given to the patients at the epileptic colony at Chalfont St. Peter, and by the courtesy of the secretary we have been furnished with the daily dietary for a fortnight. Breakfast was on each day the same, consisting of oatmeal porridge, with new milk or sugar, tea and bread and butter. Dinner consisted of roast or boiled or hashed beef or mutton, with cabbages and potatoes, followed by a rice, sago, tapioca, suet, or jam-roll pudding. Tea was accompanied with bread and butter or dripping, or sometimes golden syrup or currant cake. Supper generally included some pudding, with milk and bread, varied occasionally with soup instead of pudding. On Friday fish was given instead of meat. It must be noted that all the inmates are men. At the present time they are nearly all engaged in outdoor work for a considerable number of hours a day, which probably enables them to assimilate, without difficulty, a somewhat freer diet than would be possible in other conditions; and it is not improbable that the improved nutrition, due to the combination of active work with a dietary better than could be digested in a sedentary life, may be a not unimportant factor in relieving the disease.—*British Med. Jour.*

MEANS OF COMBATING THE PENETRATING ODOR OF THE SWEAT AND URINE OF CERTAIN PATIENTS.

—It is well known that oil of turpentine taken by the mouth imparts to the urine an odor of violets; but it is not generally known that, by prolonged

administration of this drug, the intolerable smell of patients suffering from incontinence of urine may be suppressed. According to Dr. Brassert, Assistant to Dr. H. Emminghaus, Professor of Psychiatry at the Medical Faculty of Friburg-in-Brisgau, it is sufficient to take ten minims of rectified oil of turpentine in a little milk or water three times daily to cause the odor of urine to promptly disappear completely, and replace it by the scent of violets to the great satisfaction of those around the patient. This measure, which has long been employed with invariable success of Prof. Emminghaus' wards, may be continued without inconvenience for several weeks, and is contra-indicated only in cases of ulcers of the stomach, gastric catarrh and nephritis, or when the oil of turpentine determines dyspeptic or other morbid symptoms.

This treatment is of great value, especially in cases, so frequent in private practice, in which the arrangements and constant care, necessary to keep a patient afflicted with incontinence of urine in a state of perfect cleanliness, are more or less lacking.

Another deodorant, which is also successfully employed in the psychiatric wards at Friburg in the case of patients whose cutaneous secretions are particularly offensive, is the daily administration of a bath, in which three or four grammes ($\frac{3}{4}$ —1 drachm) of permanganate of potassium have been dissolved. Such baths do not in the least affect the general condition of the patients, but under their influence the nauseating odor which they exhale rapidly disappears.—*Med. Week.*

SERUM THERAPY IN DIPHTHERIA.—AN UNSOLVED PROBLEM. — Highly favorable as have been the majority of the numerous reports on the serum treatment of diphtheria, signs are not wanting that their roseate hue may somewhat fade before the search-light of unimpassioned criticisms. It is now only a month since Dr. Hansemann, one of Professor Virchow's assistants, first drew attention to the liability of antitoxin to increase the diphtheritic tendency to nephritis, and both our home and foreign correspondents have given further evidence in this direction, as well as of other ill-effects in the shape of an increased proportion of deaths by cardiac failure, septicæmia, etc. Reports which simply give statistics of decreased mortality without any definite statement as to the mode of death, can afford us no information as to whether the effect of antitoxin on the vital organs is in excess of that which has been found to obtain under the older treatment. Since reliable information in this direction can only be derived from carefully recorded autopsies, it is to be hoped that in every case of death under this treatment a post-mortem examination will be

made, so as to prevent us falling into a Fcol's Paradise, the ejection from which could not but be attended by ignominy.—*Med. Press.*

MORPHINOMANIA IN THE MEDICAL PROFESSION.

—Dr. Jules Rochard, in the *Union Médicale*, draws a gloomy picture of the increase of the morphine habit in France and elsewhere. The habit, he finds, becomes incurable at the end of six months of indulgence. The fair sex and the doctors are, in his opinion, the most deeply addicted to morphine. He draws an unpleasant comparison between the behaviour of each kind of delinquent. Women, he says, delight in declaring how they indulge in this vice, and show ornamental hypodermic syringes to their friends. Dr. Notet states that a lady having broken the needle of her syringe in a remote country village, wounded her skin with scissors and thrust the stump of the needle into the wound, injecting herself in this manner till a new syringe arrived from Paris. Men, Dr. Rochard declares, and especially medical men, the bulk of male morphino-injectors, take the greatest pains to hide their vice. Hence the precise number cannot be estimated. He believes, however, that doctors and persons associated with them form nearly half the total of men addicted to morphine.—*Ex.*

PERMANGANATE OF POTASH IN THRUSH.—Drs. Troitski and Karntski (*Gazetta Degli Ospitali*) regard the permanganate of potash as the most efficacious remedy in the treatment of thrush in children. Besides application of an alkaline solution they also employ the permanganate locally in solution. A two to four per cent. solution of the bicarbonate of soda may be employed for alkaline irrigation, or in very grave cases a saturated solution of this substance. Besides this the physician should touch, two or three times a day, the affected spots with the following:

R—Permanganate of potash . 25 | 0 (grs. iv.)
Distilled water 30 | 0 ($\frac{z}{j}$.)

Under the influence of this antiseptic the disease rapidly disappears.—*Med. and Surg. Rep.*

TUBERCULOUS DISEASE OF THE PERINEUM, PROSTATE, ISCHIORECTAL FOSSA, AND RECTUM.—Mr. Arbutnot Lane showed a case which he had treated successfully by the introduction of glycerine and sulphur into the cavities. The condition was one of many years' standing, and had been preceded by tuberculous disease of both testicles. He commenced the injection of glycerine and sulphur on September 4th, 1894. At the present moment his pain had gone, the aperture in the bowel had closed, the ulceration about the aperture had healed, the prostate was firm, and, except for the escape of a few drops of urine occasionally from a small perineal sinus, he was practically

well. On September 4th he weighed 8 st. 11 lbs., now he weighed 10 st., a considerable gain of weight in such a short period.—*Brit. Med. Jour.*

At this season of the year, when radical and sudden thermal changes are the rule, it becomes of vital interest to the busy practitioner to have in compact, ready form, such approved medicaments as meet the analgesic and antithermic requirements of the bulk of his patients. As pertinent we call attention to the following combination tablets: "Antikamnia and Codeine," each containing $4\frac{3}{4}$ gr. antikamnia and $\frac{1}{4}$ gr. codeine. "Antikamnia and Quinine," each containing $2\frac{1}{2}$ gr. antikamnia and $2\frac{1}{2}$ gr. quinine. "Antikamnia and Salol," each containing $2\frac{1}{2}$ gr. antikamnia and $2\frac{1}{2}$ gr. salol. And "Antikamnia, Quinine and Salol," each containing 2 gr. antikamnia, 2 gr. quinine and 1 gr. salol. These, together with the well-known "Antikamnia Tablets," of varied sizes, and "Antikamnia Powdered," constitute indispensable factors in the armamentarium of the physician, and are more than ordinarily indicated in present climatic conditions.

SANMETTO IN DISEASES OF THE BLADDER AND KIDNEYS.—I have been in the practice of medicine for the past forty-four years, and say without hesitation that I have never prescribed any remedy that in its action is so near a specific in diseases of the bladder and kidney as Sanmetto, and particularly in cases of urethral inflammation combined with difficult micturition. Much might be said truthfully in favor of Sanmetto in all diseases of the genito urinary organs. I think it is the remedy for those diseases, and the best now in use.—D. CALKINS, M.D., East Lyme, Conn.

DR. CHARLES DAY, M.R.C.S., etc., 79 St. Mark's Square, West Hackney, London, writes, on January 17th, 1893: I have prescribed your preparation, Iodia, with very satisfactory results. Its power of arresting discharges was very manifest in a case of leucorrhœa, and another of otorrhœa. In the latter case, the result of scarlet fever in early life, the discharge had existed for many years. The patient could distinctly feel the action of the Iodia on the part, and the discharge gradually dried up.

WE are in receipt to-day of a copy of a special edition of Copp, Clark & Co.'s Canadian Almanac for 1895, printed for the enterprising corporation of H. H. Warner & Co., Ltd., of London, England, who are now sole proprietors of "Warner's Safe Cure." It is full of valuable information, and reflects credit on the publishers as well as on the enterprise of the English Company.

THE CANADA LANCET

A Monthly Journal of Medical and Surgical
Science, Criticism and News.

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TORONTO, FEBRUARY, 1895.

Editorial.

TOXINES IN THE TREATMENT OF INOPERABLE MALIGNANT TUMORS.

In our January number, we gave a short notice of Dr. Coley's work in the treatment of inoperable malignant tumors with the toxine of erysipelas. He has an interesting article in *The Medical Record*, Jan. 19th, 1895, on the same subject. While apologizing for the subject being trite, he asks the profession to accept no statement until it has stood the rigid tests of scientific demonstration.

Since May last he has been using injections of the toxin of bacillus prodigiosus, mixed with that of erysipelas, at the time of using. Injections are made at intervals of 24 to 48 hours, and they produce sufficiently decided reactions in some cases to make the patient keep his bed for a few hours after each treatment.

Case III. was shown by microscopical examination to be a spindle-celled sarcoma; it was of very rapid growth, and of great size, involving "the larger portion of the left thoracic wall." Owing to the enormous size and extremely rapid growth of the tumor in this case, Dr. Coley did not believe that even an arrest could be accomplished; but on commencing the treatment, the improvement was very rapid, so that in about four months "no trace of the tumor could be found either in front or behind." This the author regards as his most brilliant case, and he notes as points of unusual interest, that all the injections

were made within a radius of two inches; that the tumor disappeared entirely by absorption; and that only a single preparation of the mixed toxins was used throughout the case.

A case of tumor of the lower jaw, shown by microscopical examination to be carcinoma, was greatly improved in three weeks, but the improvement was only temporary, as were also the results in a number of other cases of carcinoma.

Dr. Coley has not yet made up his mind as to the efficacy of the treatment in carcinoma, and advises against its general adoption.

At the same time he notes, that the number of cases of carcinoma that have been permanently cured by attacks of accidental erysipelas, as well as the antagonistic effect in cases treated with toxins, should make us hopeful that soon we may achieve the same brilliant results with carcinoma that have already been shown in sarcoma. The results of the treatment in the hands of independent observers go to show the value of the toxins in sarcoma. Caution should be observed in the use of so powerful, and, as yet, imperfectly understood agent; but all cases of inoperable sarcoma should have a trial made, and, as a rule, improvement if it is to follow, will show itself in about two weeks. Individuals vary as to their susceptibility to this medicine as to others. No death has occurred from its use, though the Dr. thinks in one case the fatal event was hastened. He summarizes his cases treated thus far as follows:

"Up to May 31st, 1894, I had treated with mixed anti-toxins 25 cases of inoperable sarcoma, 8 of inoperable carcinoma, and 3 of sarcoma or carcinoma. In the cases of carcinoma, I had marked improvement in a number of cases, but no cures. The cases were all very advanced recurrent tumors. In sarcoma, I stated that there were six cases in which I considered there was a reasonable hope of permanent cure. Six months have passed since then, and none of the six cases have shown any recurrence. . . . Of my total of 38 cases of inoperable sarcoma, therefore, 9 cases promise to be permanently successful."

The whole tone of Dr. Coley's paper is that of absolute fairness, and we can easily see that, had he been led away by too great enthusiasm as to the treatment, or allowed himself to be in the least sanguine, at any rate on paper, he could

easily have made a very different showing. The whole medical profession will await further developments along this line, and wish Dr. Coley and other workers in this hitherto hopeless field a hearty God-speed.

A NEW QUESTION IN MEDICAL JURISPRUDENCE.

The insanity dodge, to avoid the result of criminal acts, has been rife in courts of law for many long years, and especially so, we think, in the past two decades. Though so often tried it has not in many cases proved of much service to the malefactor; his mental condition having been shown, in nearly every instance, to have been such that he was responsible for his acts. The assumed disease never shows itself until after the commission of the crime, and the detection of the criminal; which circumstances together with the examination of the feigned insane person, by experts, nearly always, we may suppose, results in the placing of the suspect in the proper position as to mentality.

But hypnotism brings a new question before the medico-legal world, and one which, we are inclined to think, will prove an extremely difficult one to thresh out. Ernest Hart is on record as having said, "It has been shown that not only will a hypnotic subject perform unconsciously, under the influence of suggestion, acts which are dangerous to himself and others, and which are in themselves criminal—so that he can be made to thieve, to commit arson or to attempt violence—but that certain subjects can, there is reason to believe, be made to receive a suggestion having in it a time element. He can be told: 'On this day week, at a given time, you will return to the hypnotic state, you will go to a given place, you will steal such and such property, or you will attack such and such a person, and you will not remember who gave you the direction.'"

Criminal lawyers will not be slow to take up this statement by Dr. Hart, made, no doubt, after due deliberation as to the far-reaching effects of such conclusions placed before the world by one who stands so high in his profession. It can easily be seen how unfortunately placed the ordinary physician will be in criminal cases, as to any

weight his evidence will have, if it goes against this plain statement of possibilities by I. r. Hart.

A case in point has recently been furnished by the result of a trial in Wichita, Kansas. A man, Patton, was killed by the self-confessed murderer, McDonald. McDonald was acquitted by the jury, under the instruction of the judge, on the ground that he had committed the crime while he was under the hypnotic influence of his employer, one Gray.

The evidence in the case showed that Gray was a man of strong personality, of a commanding presence, and dominating manner; that, he and not McDonald, had a *motive* for the killing of Patton, the latter having been a witness against Gray in a law suit of much importance. Under the dominating will-power of Gray, McDonald was shown to have been obliged to lie in wait for, and shoot Patton.

Not only did the court go so far as to acquit McDonald; but afterwards, in a separate trial, convicted Gray of murder committed by his agent, and sentenced him to death.

So now we may expect an epidemic of hypnotic suggestion, and more trouble over the much vexed question of *responsibility*. The psychopathist will not only have to decide as to the "mental disturbance arising from disease," the old and true test, but will have to weigh and measure the amount of *will* the criminal had remaining. And here, Mittermaier, who wrote long before hypnotism as such was ever heard of, will be in evidence, for he holds that the *will* is the most important factor in any given case, and "rebukes the English jurists for the rigid adherence to the antiquated doctrine, that whoever can distinguish good from evil enjoys freedom of *will*." In his opinion it is not a question as to whether the accused one was aware of the criminality of his action, but whether *he had lost all power of control over his actions*. Ordronaun practically agrees that *will* is the test of responsibility in any case.

Now, the opinion of such men, coupled with Dr. Hart's statement, makes what appears a hopeless muddle, in attempting the discovery of truth, the great purpose of the law. Why, for instance, might not the *victim* in certain cases be shown to have hypnotized the murderer and forced him to do the act, rather than that the murdered man

should commit suicide? Reese says, as bearing out this suggestion that, "Some have been known to commit murder with the avowed intention of receiving the punishment of death at the hands of the law, instead of inflicting it suicidally upon themselves."

The above considerations form subject matter for grave thought as to the advisability of making all hypnotic experiments illegal.

TREATMENT OF DIPHTHERIA WITH ANTI-TOXINE.

The past experience of the medical profession of this country with the fads of the German and French physicians has made us a little shy of the serum therapy. We have, therefore, avoided commenting on the new treatment until further evidence of its value are forthcoming.

We have long since learned to discredit the statements of the enthusiasts upon any subject, as we are almost always incapable of judging of the real merits of their work. In this instance it still remains for the honest men to determine the value of the anti-toxine treatment, the practical investigation of which presents many difficulties. It is gratifying to know, however, that the serum obtained from the horse, previously injected with pure culture or toxine of diphtheria bacilli, is free from any dangerous or deleterious properties; consisting as it does of serum of the animal, rendered immune by the effect of the most poisonous culture by the slow process of injections. It is quite harmless to the patient, therefore, provided we do not abandon or subordinate the old and successful treatment by well-tried remedies, such as the tincture of chloride of iron, persistently employed; hydrogen peroxide, the calomel treatment; the bichloride; quinine, and stimulants. One or more of these plans of treatment, with close watchfulness of the temperature of the room, absolute rest, good diet, with proper attention to the bowels and bladder, has given excellent results in the vast majority of cases. In fact, many of our most truthful and reliable members of the profession are willing to testify that they rarely lose a case under their favorite plan of treatment, provided they are called in its incipiency. When the posterior nares or larynx, or both, are involved,

the mortality has almost invariably been quite large, under any treatment heretofore practiced. If the anti toxine can be shown to be of any great value in such cases, especially in laryngeal cases, and will prevent the death of any considerable per cent. of them, then, and then only, will it be accepted as a valuable addition to our armamentarium of cures for diphtheria.

If the reports be true, or even if the half that is told is true, the anti-toxine treatment has been of considerable service in this disease. Its real value, however, must of necessity be a matter of considerable speculation, inasmuch, as we have already stated, that so many claim to be able to cure diphtheria with ordinary medical treatments. Again, though the blood serum is harmless to the patient, it may be at the same time inert in many cases.

Can we be positive that the animal has been properly treated before the serum is obtained? Will the profession not be liable to the perpetration of fraud by those who may desire to speculate? To our mind there is but one way to be certain that we are procuring anti-toxine in the blood serum that we may demand; that is that the Government take hold of this matter and employ salaried officials to carefully prepare and preserve the serum for use as it may be demanded. The test of the value of the serum now before us is by no means reliable.

It is an established fact that the manifestation of the virulence of the disease varies very much in different seasons and in different localities. The attack of members in the same family varies. It is well known that when diphtheria attacks a large family of children, the first one taken with the disease is usually the one to die, if any; and that it becomes milder as it progresses in the family; whether this is due to the prompt treatment in the later cases, or to an attenuation of the virus, we do not pretend to say.

In epidemics the virulence is much greater at the commencement than towards the close. Another perplexing question, and one that seems difficult of solution, is to ascertain whether certain cases are diphtheria or follicular tonsillitis. The culture test only, in the hands of experts, is capable of determining this matter. With these truths before us, when are we to arrive at a conclusion regarding the efficiency of the anti-toxine treat-

ment? However, as we have before stated, it is harmless, and it may be of great value. Therefore, if we are not imposed upon, and do not have to "pay too much for our whistle," it is advisable to experiment with the new remedy.

SALICLATED-IRON MIXTURE.—*Phila. Polyclinic.*

R—Sodii salicylatis, ʒ iv.
 Tinct. ferri chloridi, f ʒ iv.
 Acidi citrici, grs. x.
 Glycerini, f ʒ iss.
 Ol. gaultheriæ, ℥ viij.
 Liq. ammon. citratis, q.s. ad, f ʒ iv. ℥.

Sol. sec. art. dos. f ʒ j or f ʒ ij.

Dissolve the citric acid and sodium salicylate in the liquor ammonii citratis. To the glycerine add the tincture of iron chlorid, and then mix the two solutions, finally adding the oil of gaultheria. One or two drams of mucilage of acacia would be a valuable addition with which to emulsify the oil of gaultheria.

In this prescription reaction takes place between the ferric chloride and sodium salicylate, resulting in double decomposition, giving iron salicylate, in the first solution. Care should be taken to keep the liquor ammonii citratis in slight excess, in order to have a perfectly clear solution of salicylate of iron.

Dose.—One or two teaspoonsful.

The prescription is used principally in the treatment of chronic cases of rheumatism or rheumatoid arthritis, in which anæmiæ or evidence of impaired nutrition is a distinct feature. It is likewise employed in acute tonsillitis of rheumatic origin, and in acute articular rheumatism in ænemic subjects, especially if the patient has suffered from one or more previous attacks.

The ordinary dose in chronic cases in adults is a dessertspoonful four times a day; in acute cases the same dose is given every two hours until tinnitus is produced or decided amelioration has occurred, when the dose is diminished or the intervals between the doses lengthened.

THE SURGICAL TREATMENT OF EMPYEMA.—Ashhurst, Jr., *Int. Med. Mag.*, gives as his opinion that no operation is justifiable unless the presence of pus is certain; and thorough treatment by medical agents, blisters, etc., has failed, or unless

the symptoms, dyspnea, etc., demand immediate relief. Diagnosis is exceedingly difficult, and there are no absolute symptoms or positive signs, indicative of the presence of pus. Simple aspiration, tapping the sixth or seventh interspace, with antiseptic precautions, is preferred to the hypodermic syringe or exploring needle, as by the former the operator can promptly evacuate when a diagnosis is determined. If the fluid is purulent or becomes so, incision and drainage should be practiced, making two openings, and carrying a large drainage tube through the cavity from one opening to the other. Supplementing the drainage by washing out the cavity with a mild solution of boracic acid is advantageous. Resection of one or more ribs, when the lung is so bound down by adhesions that it cannot expand, in order to allow collapse of the chest-wall, and to promote healing by bringing costal and visceral layers of the pleura into contact. Because of the risk of necrosis, osteoplastic resection is not recommended.

CROUP AND ALL CROUPOUS DISEASES CURABLE BY PILOCARPINE.—Carl Sziklai, *Journal of Laryngology, Rhinology and Otology*, in an elaborate thesis read before the Ecole de Medicine in Paris, in which he describes the anatomico-pathological processes observed in croup, and its differentiation from diphtheria, concludes: 1. Pilocarpine is a specific for croup and all croupous diseases, *i. e.*, croupous laryngitis, croupous bronchitis, croupous pneumonia, croupous nephritis, croupous cystitis, etc. 2. The action of pilocarpine commences at once. In laryngitis crouposa cure is obtained in a few hours; in pneumonia crouposa in two or three days. 3. The result is certain, whether taken by mouth subcutaneously injected; also applied as suppositories or globuli vaginales. 4. In an advanced stage of laryngitis crouposa, with imminent danger to life, subcutaneous injection is preferred to internal administration. 5. By pilocarpine not only is duration of disease notably shortened, but mortality is *nil*. 6. In suitable cases, given early enough, it has a preventive action. 7. Pilocarpine can be given in twice officinal dose without fear of ill effects. The author's experience with this drug in treatment of croupous diseases extended over two and a-half years, and embraces over one hundred cases. His conditions and ob-

servations were corroborated by Herr Hofrat Biederl, of Hagenan, and Eschevich, of Graz.

CYSTITIS IN THE FEMALE, WITH SPECIAL REFERENCE TO TREATMENT.—John C. Hersler, Ph.G., M.D., *Univ. Med. Mag.* The chief indications for treatment are :

1. To remove any discoverable source or sources of irritation which act through the medium of the urine. This may be affected by a milk diet, and a discontinuance of the use of acids, pepper, etc. Any mechanical source of vesical irritation should receive appropriate treatment.

2. The urine should be rendered bland by the use of a milk diet, the ingestion of considerable quantities of water, the administration of potassium citrate, if the urine be too acid, or of boric acid if it be alkaline.

3. Pelvic congestion should be relieved by hot vaginal douches, placing the patient in the knee-chest position; and the correction of constipation.

4. The inflamed cystic mucous membrane may be relieved by the administration of boric acid, salol, ol. santal, copaiba, or creosote by mouth; or the use of injections of boric acid, carbolic acid, of nitrate of silver in suitable strengths.

5. The patient's general health should be improved by tonics, etc.

6. Rest in bed, especially in all acute cases, is absolutely imperative.

While advocating direct local treatment for cases of cystitis which do not readily respond to ordinary therapeutic measures, the writer advises that it should be employed with judgment and caution.

THE DISCUSSION ON THE VALUE OF THE DIPHTHERIA ANTITOXIN at the Berlin Medical Society, was concluded at the third session of the society. *Med. Rec.* Dr. Schiemmann warned general practitioners against employing the antitoxine, which he said should be left to hospitals for the present. Professor O. Liebreich, director of the Pharmacological Institute of the University, criticised the published serum statistics. He said that the Berlin hospitals had always had a much higher percentage of deaths from diphtheria than the Berlin town practice. This was because, broadly speaking, only serious cases were brought to the hospitals. But since the introduction of the serum

treatment, a far greater number of cases—and cases of all sorts—had been brought to the hospitals, and so it was quite natural that the percentage of deaths had fallen considerably. He considered the serum treatment to be based on fallacies very similar to those which had formed the foundation of the tuberculin treatment. It would be interesting to find out, he added, what action on the organism injection of pure serum would have. Dr. Hansemann, in a few last words, stood to his view that antitoxin is not to be regarded as a specific for diphtheria.

AN American friend of mine, *Ed. Med. Times*, relates the following incident which occurred during his residence in one of the prohibition States. A practitioner in a small country town, where the sale of liquor was prohibited, except on a *bona fide* prescription of a medical man, desired to prescribe some whisky for one of his patients. The chemist to whom the prescription was intended to be sent being a somewhat scrupulous person, the doctor scratched his head and said that he feared unless he took particular pains his patient would not be able to get the prescription dispensed. Therefore, he wrote the same in the following manner :

R—Spts. Frumenti q.s.

and at the bottom he added the following lines :

Please give the bearer the above-named potation,
He's a pretty good chap and employed at the station,
The liquid he craves is known as frumentum,
And the name at the bottom will tell you who sent 'im.
The letters q.s., to be very explicit,
Is a medical dodge known as quantum sufficit,
But if a special translation you crave for,
'Tis simply this—give him all he can pay for.
Now do not refuse this my poor requisition
For I'm sound on the goose and an old school physician.

It may, perhaps, be as well to add that the prescription was duly dispensed. When the Local Option Bill passes I have no doubt that many of us will be called upon to prescribe for similar cases and earn many a fee thereby.

THE VALUE OF REPEATED LAVAGE AT SHORT INTERVALS IN OPIUM POISONING.—Hamburger, *Johns Hopkins Hospital Bulletin*, reports a case of opium poison in a Chinaman, illustrating the importance of repeated lavage. It was thought that all the

poison had been removed from the stomach at the first washing, but two subsequent washings, performed at intervals of several hours, yielded alkaloidal reactions. This reaccumulation of the alkaloids must have resulted from an excretion by the gastric mucous membrane, for it has been shown that it is in the stomach that the elimination of morphine proceeds most actively. In view of this fact, the writer concludes that repeated lavage to remove the alkaloids as fast as they are eliminated must certainly be a life-saving process, whether the poison has been taken by the mouth or hypodermically. The washing should be practiced at short intervals, and the sooner this can be done after the opium or morphine has been taken the better.

CANNABIS INDICA.—This drug, the most active of non-opiate anodynes or soporifics, which was very popular years ago, although little the-fashion at present, is deserving of a large share of professional favor, *Med. Rev.* The principal cause which led to its disuse was fear of its toxic power, though there has never been a case of poisoning recorded from its use. Its effect on the system is most marvellous. It causes sleep, overcomes spasms, relieves pain and all nervous irritability, and that too within a few moments after administration. Its soothing and curative effects upon the nervous sympathetic system are great, and there is no one agent that will restore the equilibrium of nerve motion more quickly. The placidity of repose that is produced by this narcotic is rapid and to the point. Further, it does not check secretion or tend to constipation. It does relieve fatigue and arouse vital action, and can and should be given freely until the effect desired is apparent.

ERGOT FOR THE NIGHT SWEATS OF PHTHISIS—Goldendach, *Br. Med. Jour.*, thinks that the night sweats of consumptives are not simply due to fever, and that their real cause has not yet been fully explained. Many remedies have been recommended for them—quinine, acetate of lead, atropine, hyoscin, brandy, rubbing the body before sleep, or using a powder composed of starch, talc, and salicylic acid. Most of these Goldendach has tried and found wanting. On considering the part probably played by the vasomotor nerves, he

determined to try the effect of ergot against night sweats, and in most cases found the result very satisfactory. He usually gives one or two 5 grain doses of powdered ergot before bed time, and the cases are few in which this remedy is found quite useless. He has, moreover, never seen any harm result.

BASSINI'S METHOD FOR RADICAL CURE OF HERNIA.—This method consists essentially in the following procedure: The sac is carefully dissected out, ligated, the hernia reduced, and the sac ligated and cut off as close as possible so that it will retract into the abdominal cavity. The internal oblique and transversalis muscles are then stitched back to Poupart's ligament, the cord being drawn aside in the meantime. The cord is then laid over these muscles, and a roof and a new canal formed by stitching the skin to the superficial fascia over the cord. Some operators make three layers of sutures, placing the cord between the layers of the superficial and the deep fascia.

HURON MEDICAL ASSOCIATION.—The Huron Medical Association met in Seaforth on the 15th inst., with Dr. Turnbull, President, in the chair. Papers were presented by Drs. Campbell and Burrows, of Seaforth. Dr. Graham, Brussels, introduced the question of manner of collecting Medical Council fee, and this elicited considerable discussion. The subject of Medical Ethics was taken up by Dr. Wood, Mitchell, Dr. Bethune, Seaforth, and Dr. Shaw, Clinton. The annual election of officers took place and resulted in the appointment of Dr. A. Dalton Smith as President, Dr. A. Bethune, Vice-president, and Dr. Mackay secretary-treasurer.

LOCAL APPLICATIONS IN DIPHTHERIA.—Dr. White, resident physician at the Willard Parker Hospital, New York, says, *Med. Times*, that his experience with peroxide of hydrogen in diphtheria, at that institution, had been very unfavorable. All the cases showed some sign of irritation from the peroxide. Cleansing with plain water or normal salt solution was best. Dr. Jacobi, New York, used only physiological salt solution, or lime water, introduced gently through the nose. He regards it as criminal to bore into the mouth of a child and try to pry open its jaws while it is struggling and becoming exhausted. Besides, the

affected parts cannot be reached in that way, while they can be through the nose.

NEW PARTNERSHIP.—Owing to the increase of work at Bellevue, House, Dr. Temple's private hospital, Dr. Temple has taken Dr. A. A. MacDonald into partnership with him in connection with his hospital work. Although Dr. MacDonald's partnership with Dr. Temple is limited to the hospital, yet his experience in gynæcology has been very extensive, and he will prove of valuable assistance to Dr. Temple, and relieve him, to a certain extent, of the great demand made upon his time in connection with the hospital. We are pleased to know that Bellevue House still continues in popular favor with the profession throughout the city and Province. Dr. Temple's long connection as a teacher of gynæcology and abdominal surgery, and his great practical experience in addition to the experience of Dr. A. A. MacDonald will ever command for the institution that confidence and esteem from the members of the profession which will ensure its success.

WEST TORONTO TERRITORIAL DIVISION ASSOCIATION.—The annual meeting of this association was held in Broadway Hall on Jan. 12th., at which a large representation of the members of the Division were present. The subjects of lodge practice, account collecting (including a black list of bad pay patients) and repetition of prescriptions by druggists, were discussed, and committees appointed to consider each of these and report at the April meeting.

The election of officers resulted as follows: President, H. T. Machell; 1st Vice-President, A. A. Macdonald; Sec. Treas., Geo. H. Carveth; Council: A. McPhedran, J. Spence, J. Ferguson.

The next regular meeting of the Association will be held in Broadway Hall, on Wednesday, April 10th. at 4 o'clock.

THE INFLUENCE OF CHLOROFORM ANÆSTHESIA IN OSTROMALACIA.—On the ground of an experimental study of the effect of chloroform in ten cases of osteomalacia made at the clinic of Prof. Schauta, Dr. Latzko arrives at the following conclusions:—*Wien. Klin. Woch.*

1. In the majority of cases chloroform anæsthesia is followed by marked improvement of the symptoms of osteomalacia.

2. This improvement always took place rapidly.
3. That in almost all cases, however, after a variable time the condition again changed for the worse, and this was usually coincident with the appearance of the menses.

TO CLEAN NICKEL PLATE.—Articles of nickel or nickel-plate may be cleaned, *Lit. Dig.*, by laying them for a few seconds in a mixture of one part sulphuric acid and fifty parts alcohol, washing with water, rinsing with alcohol, and rubbing dry with a linen rag. This process cleans perfectly, and should be especially useful on plated articles, on which the usual cleaning materials act very destructively, cutting through the plating and causing it to flake off. The yellowest and brownest nickeled articles are restored to pristine brightness by leaving them in the acid solution for a quarter of a minute. Five seconds are usually sufficient.

FLATULENT DYSPEPSIA.—Flatulency, or simple eructations of tasteless gas, after eating or drinking the least quantity, is a terrible bore to many people, Dr. Livesey in *Med. Sum.* Everything they eat or drink seems to create gas in the stomach—all is *ventis at preterea nihil*. Well, here are three prescriptions with a little advice that may help the tried physician's patience, and the more tried patients' patience, who has been swallowing drugs *ad infinitum* with no relief—he or she still eructs. Flatus generally results from the excessive formation of gas; then let us try sulphurous acid, strychnine or nux vomica, etc.

R—Acid sulphurosi, ʒ i-ij.
Tr. nucis vomicæ, ʒ j.
Tr. card. comp., ʒ ss.
Aqua, q. s. ad. ʒ iv.—M.

SIG.—One teaspoonful in water after meals.

Or, in atonic cases—and these cases may generally be atonic, and a local stimulant to the stomach is needed with an anti-fermentative and antiseptic agent—then creosote is an admirable remedy. Give half to one hour after meals. It may be combined with bicarb. of soda or subnitrate of bismuth, somewhat after this formula:

R—Creosote, gtt. x.
Bismuth, subnit. or subcarb., . . . ʒ ij.
Mucil. acacia, ʒ v.—M.

SIG.—Mix well and give two teaspoonfuls about one hour after meals.

Pepsin or lactopeptine may also be required—any physician can combine either of these articles with creosote, bismuth, etc., to meet the case or his views. Powdered charcoal with soda or bismuth or magnesia, rhubarb and a little ginger or capsicum often act well, temporarily at least, till the stomach is toned up by other agents; a few drops of oil of cajuput put in sugar often relieves.

PUERPERAL CONVULSIONS.—Charpentier states, *Med Annual*, that if, during pregnancy, there is albumen in the urine, however small the amount, an absolute and exclusive milk diet should be insisted upon from the start. It is, *par excellence* the preventative treatment of eclampsia. If a convulsion occurs, and the patient is vigorous and very cyanotic, she may be bled to the extent of 16 ounces, and then chloral and milk given as soon as possible; if she is not strong, the chloral alone is sufficient. Labor should be allowed to begin spontaneously, and to progress without interference.

ICTHYOL IN PROSTATITIS.—This substance introduced into the rectum by injection or suppository has proved very beneficial in prostatic inflammation, *Rev. Méd.* Amelioration of the symptoms quickly occurs, pain during defecation, urinary uneasiness, etc., disappear, and the gland returns to its normal condition. The suppositories contain about 5 grains ichthyol, and one is used night and morning.

THE VAGUS AND THE SECRETION OF ACID BY THE STOMACH.—Leubuscher and Shafer, *Centralblatt f. Innere Medizin; Med Age*, who are duly corroborated by Pawlow, Schumova and Krehl, have proved by experiments that section of both vagi below the recurrent laryngeal nerves induces waste, loss of appetite and ultimate death. In animals in which such section was performed no free hydrochloric acid was found in the stomach, and the gastric juice exerted little digestive action.

FIFTY-THREE IMMORTALS.—The name of Dr. W. T. G. Morton has been inscribed on the base of the dome of the new chamber of the House of Representatives of Massachusetts, along with fifty-two other sons of the State, selected as representing the highest favor of the Commonwealth. It

will be remembered that Dr. Morton was the discoverer of the safe use of ether as an anæsthetic. The honor done his name is none too great, and has been, to say the least, somewhat tardy.

HEADACHE.—Lauder Brunton calculates that 80 to 90 per cent. of all headaches are due to defects of vision (hypermetropia, myopia, astigmatism, disparity in the local distances of both eyes, deficient power of convergence). Ten per cent. are caused by bad teeth and about five per cent. by affections of the nose, ears or scalp, and other factors. The headache of the first group is usually seated in the forehead, the temples or the occiput; where the visual power is not the same in both eyes it frequently attacks the weaker side.

PHENACETINE IN URINARY AFFECTIONS.—Dr. W. Holladay, *La Semaine Méd.*, has employed phenacetine successfully in treating nocturnal incontinence of urine in children, as well as to decrease the frequency of micturition in prostatic subjects, and especially when there is co-existent cystitis. In children the remedy is taken on going to bed, in a dose of four grains; in prostatics one may administer eighteen grains, also on retiring.

PILOCARPINE IN ALCOHOLISM.—In alcoholism, Dr. Josham recommends, *Prov. Med. Jour.*, one-third grain doses of pilocarpine hypodermatically, and declares its "sobering effects are remarkable;" sleep ensues, and the patient wakes up a perfectly rational being. "The tense, red, bloated countenance and bleared, congested condition of the eyes pass away, the features become calm and easy, the skin soft and clear."

"THE DOCTOR."—We have recently received a copy of this now celebrated picture. It is issued by the Arlington Chemical Co., Yonkers, N.Y., and is printed in fourteen different colors, in imitation of oil painting. It is a beautiful thing for office or study, and will be sent to any one sending \$1 to the above Co., including their bright little paper "The Factotum."

HEADACHE.—

R—Caffeini citrat., } $\bar{a}\bar{a}$. . . $\bar{\text{D}}\bar{\text{i}}$.
 Ammon. carb., }
 Elix. guaranae, $\bar{\text{J}}\bar{\text{i}}$.—M.
 Sig.—Teaspoonful every hour until relieved.

CHAPPED HANDS AND FACE, *Gaillard's Med.*

Jour. :

- R—Tr. benzoin co., ℥ x.
- Alcohol, ʒ ij.
- Aqua rosæ, ℥ xxx.
- Glycerine, q. s. ad. ʒ j.

M. Sig.—Apply to chapped surfaces at night, after they have been washed with soap and warm water and thoroughly dried.

A second application is rarely required. This remedy is equally efficacious in the treatment of fissured, bleeding and sore lips.

FOR THE GREEN DIARRHŒA OF INFANTS, *Practitioner* :

- R—Acidi lactici diluti, ʒ iv.
- Tincturæ limonis, ʒ j.
- Syrupi,
- Aquæ, āā ʒ ij.

M. A teaspoonful thrice daily after suckling.

NEURALGIA.—For stubborn neuralgia try the following, *Med. Reprints* :

- R—Antipyrine, ʒ jss.
- Caffeine, ʒ ss.
- Ext. cannabis ind.,
- Ext. aconiti, āā gr. ijss.
- Hyocyami hydrobromat., . . . gr. ʒ.

M. Ft. capsules No. xxx. Sig.—One every two or three hours.

GONORRHŒA.—Vatier, *Therap. Leistung; Brit. Med. Jour.*, recommends a combination of antipyrin and corrosive sublimate as an injection for gonorrhœa :

- R—Perchloride of mercury, . . . 1 part.
- Antipyrin, 100 parts
- Distilled water, 10,000 parts.

The injection should be used four times a day, and retained as long as possible. The addition of antipyrin prevents smarting.

VOMITING OF PREGNANCY.—A writer in the *Lancet* says: "I have not failed once in many years, by a single vesication over the fourth and fifth dorsal vertebræ, to put an end at once to the sickness of pregnancy for the whole remaining period of gestation, no matter at what stage I was consulted. The neuralgic toothache, and pruritis pudendi of the puerperal condition yielded as readily, and to one application.

CORN CURE.—

- R—Cocaine hydrochlorate, . . . 2 grs.
- Salicylic acid, 30 grs.
- Alcohol, 120 minims
- Solid ext. cannabis indica, . . 8 grs.
- Collodion, 120 minims

Apply to the corn by any convenient means.

CHRONIC GONORRHŒA, *Marcus* :

- R—Hydrarg. ox. flav., grs. iv.
- Lanoline,
- Vaselin alb., āā ʒ ss.
- Ol. olivæ, q s.

Apply to urethra by means of flexible French bougie of suitable size.

INSECT BITES, *Medical Age* :

- R—Ammonia water, 45 minims.
- Collodion, 15 minims.
- Salicylic acid, 1½ grains.

One drop to be applied to each spot affected.

RESOLUTION OF CONDOLENCE.—At a meeting of the Toronto Medical Society, held January 24th, a resolution expressing the sympathy felt by every member with the widow of the late Dr. J. E. White, in her recent and terribly sudden bereavement, was unanimously adopted, and a committee composed of Drs. Wm. Britton, and N. A. Powell was appointed to convey the same to her.

We have received the first issue of a new medical journal, *The Canadian Medical Review*. The staff consists of Drs. W. H. B. Aikins, A. B. Atherton, J. H. Burns, G. Sterling Ryerson, J. Ferguson, Albert A. Macdonald, and D. W. Montgomery. We wish the new journal every success.

HÆMORRHOIDS.—Tuttle uses the following solution as an injection fluid. He never injects more than four minims at a time, even in the largest hæmorrhoid.

- R—Ac. carbolici ʒ iss.
- Ac. salicylici ʒ ss.
- Sod. bibor. ʒ i.
- Glycerin ad ʒ i.

THE USE OF ICE IN ASTHMA.—Dr. Sangree has succeeded in cutting short, *Bulletin Gen. de Therap.*, a spasm in a severe attack of bronchial asthma by applying ice over the course of the

pneumogastric nerve at the root of the neck. Five minutes after the application the spasm relaxed completely, and the patient slept, after having been four days without sleep.

FOR BRONCHIAL ASTHMA.—*Provincial Med. Jour.*:

R—Extracti stramonii, gr. $\frac{1}{8}$.
 Potassii iodidi, gr. v.
 Ammonii carbonatis, gr. iv.
 Tincturæ lobeliæ æther. . . . ℥ v.
 Aquæ chloroformi, q. s. ad $\bar{3}$ ss.

Misce et fiat mistura.

SIG.—A tablespoonful from every four to six hours.

BORO-SALICYLIC SOLUTION introduced by Cesaris and Carcano, as an antiseptic, *Merck's Med. Rep.*, contains to every litre (say quart) four grammes (1 $\bar{3}$) each of boric and salicylic acids. Its therapeutic value has recently been tested in an Italian hospital and found superior to that even of corrosive sublimate. The addition of the boric acid renders the salicylic acid solution more permanent.

AN ANTIDOTE TO HYDROCYANIC ACID.—The *Lyon Médical, N. Y. Med. Jour.*, for October 4th says that M. Johann Antal, a Hungarian chemist, has discovered a new mineral compound, nitrate of cobalt, which promises to be a very efficacious antidote in cases of poisoning with potassium cyanide or hydrocyanic acid. Tried first on animals, this product has since been employed, always successfully, in more than forty cases of accidental poisoning.

PERSONAL.—The report that Dr. Wm. Osler had accepted the Deanship of McGill Medical Faculty is not true. The Dr., although a Canadian, finds more congenial work in Baltimore.

Books and Pamphlets

ON CHOREA AND CHOREIFORM AFFECTIONS. By William Osler, M. D., F.R.C.B., Lond., Professor of Medicine, Johns Hopkins University, Baltimore, etc. Pp. 120. \$3.00. Philadelphia: P. Blakiston Son & Co. Toronto: Carveth & Co.

This is an exhaustive work on the disease so common and yet so little understood—chorea.

The author well designates it an *olla podrida*. Dr. Osler has drawn largely from all available sources, and the result is an admirable work which will be read with pleasure and profit by all practicing physicians.

SYLLABUS OF GYNÆCOLOGY; Based on the American Text Book of Gynæcology. By J. W. Long, M. D., Richmond, Professor of Gynæcology and Pediatrics in the Medical College of Virginia, etc. Philadelphia: W. B. Saunders. Toronto: Carveth & Co. Pp. 132. \$1.00. 1895.

The author had three objects in view in compiling this syllabus: First, to be used as notes by lecturers; second, to enable students more intelligently to follow and remember the lectures, and finally, as a convenient reference, for practitioners. In certain cases the author differs from the American Text Book of Gynæcology, and has added to it according to his judgment.

It is very conveniently arranged, paged to show the corresponding pages of the larger work, and figured to show where illustrations are to be found. A very handy book for lecturers, students, and practitioners.

THE DYSPEPSIA OF PHTHISIS; its Varieties and Treatment. Including a description of certain forms of dyspepsia associated with the tubercular diathesis. By W. Soltau Fenwick, M. D., B.S., Lond., M.R.C.P., Lond. Assistant to the Evelina Hospital for Sick Children. London: H. K. Lewis, 136 Gower St. Toronto: Carveth & Co. 1894.

This work is a detailed description of the dyspepsia of pulmonary tuberculosis. The investigations on which the book is based have been carried on since 1887, and deals not only with the stomach, but also with the other parts of the whole alimentary tract.

The work shows a vast amount of study and personal research on the part of the author, and may be considered the best and latest on the subject in hand. And when we consider the immense importance of *nutrition* in tuberculosis, and that so long as a patient can keep his weight, or better, increase it, there is always a fighting chance of his throwing off his disease, we shall appreciate the interest which should be taken in the subject of indigestion by every practicing physician.