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Selections: Medicine.

DIARRHŒA AND ATHREPSIC ERYTHEMA OF THE NEWLY-BORN.

(PARROT.)

(Translated for the CANADIAN JOURNAL OF MEDICAL SCIENCE.)

The diarrhœa of young children and especially of the newly-born, to which we are exclusively directing attention, is not a disease, it is not an affection, for it cannot be connected with any fixed organic condition: it corresponds to very different modalities of the digestive functions, and is met with in very different lesions of the intestinal tube. We cannot absolutely look upon it as a disease; it is only a symptom, only a clinical fact which is observed by the bedside of children, and we will study it only in this point of view, entirely limiting this lecture to the diarrhœa of the newly-born, in no wise wishing to write a chapter on general pathology, and reserving our study to the diarrhœa of very young children and especially of the newly-born. We will then limit our study to a practical point of view, and consider diarrhœa only at the age at which we are observing it, that is to say in the three first months of extra uterine life.

Let us begin our study with that of normal intestinal dejections. In the little new-born child, immediately after birth, we find first a very peculiar special excrementitious product, meconium (from the Greek *μυκωνιον*, poppy juice, to which it bears a certain analogy). Meconium exists after the end of the third month of uterine life, but at that time it presents a different aspect. It is only at the fifth

month that it takes all the characters which we find in it at birth. During the three days which follow the birth, the child passes some meconium. It has the appearance of an unctuous, pasty, pitchy matter, coming out in the form of a small pudding, spreading over the buttocks, and on the sheet, and intimately adhering to it like pitch, and when we remove the coverings from the little child we separate them only with difficulty. The meconium itself stretches like an elastic band, before separating from them.

It presents a very dark green tint, sometimes blackish. It contains no solid matters. To the touch as to the sight it is a soft and unctuous substance. It rarely persists beyond two or three days. Towards the end it is already mixed with a clearer yellow matter, and less unctuous to the touch: the meconium is about to finish.

As to its constitution: it contains more than 700 parts to 1,000 of water, and an enormous quantity of mucus and epithelium from the stomach and especially from the intestinal tube, which appears to be the first body which constitutes the meconium. This epithelial waste would irritate the surface of the intestine and would provoke afterwards an exaggerated secretion of bile, which, in fact, exists there in large quantity, likewise well marked by its colouring matters and biliary acids. Salts in quite large quantity are also found.

We may here be asked, how it is that meconium is accumulated thus from the third month without being eliminated into the amniotic waters. Now it cannot get out of the intestine, because, to expel fecal matters a certain effort is necessary, and for this effort

the child must respire: so when it is in the free air and has respired, this effort is made and meconium expelled. Some is passed at times even during the course of the labour, but it is by pressure coming from the mother and exercised indirectly upon the body of the fœtus during labour.

Let us now pass to the study of normal stools, properly speaking. They are something quite special, they have a peculiar aspect, yellow, the yellow of buttered eggs, as well to the sight as to the touch. They are not humid but they are unctuous. They have no odour. They are in number two, three—rarely four in the twenty-four hours. They are not solid and formed, but spread themselves out slightly, forming small limited masses. They are made up of a large quantity of colouring matters of the bile, which gives, to them their fine bright yellow tint, and which are but little altered, according to Lehmann, since they have preserved their reactions. We find afterwards some casein which has scarcely been attacked by digestion, also fatty particles of milk and a small quantity of epithelium. Lastly, a very large quantity of microphytes of micrococcus are found there, which exist in the most normal stools, and which it would be very necessary to be careful of considering as causes of alterations when we will meet them also in great quantity in various pathological stools.

Let us name now matters of transition which are not really more normal, although most physicians and mothers are generally contented with them. They are already pathological: they no longer have the same degree of consistence—dryness and homogeneity. They are a little more fluid, less unctuous, less coloured, more acidulated, and, in contact with the air, they become green spontaneously: this is a pathological indication.

The pathological motions present different special characters. We can state precisely their number. It varies according to the quantity expelled at each stool. There are some children who have a great number of them—ten, thirty—because at each suckling, at each movement, they have a small stool. Their consistence is fluid to very different degrees; they spread themselves out and cover a great surface of the

linen; a portion of the bed is also spotted by the intestinal matter properly speaking, and around these spots is seen a wet liquid, colourless, zone, which must not be believed due to the urine, but which is wet by the water, which comes from the intestinal tube, and which separates itself from the solid matter. At that time it is necessary to be very careful in attributing to an abundant flow of urine what we have already pointed out as a sign of good health. The spots made by the urine do not form so regular a zone, and are seated on the most anterior parts of the bed.

The colouration of these pathological motions differs sometimes very little from the yellow tint: it is always whiter and duller. Usually they turn green in contact with the air, though sometimes they do not. They are made up in the beginning of small masses, of small striae of green in the midst of the yellow matter. The green becomes more and more marked. At a more advanced stage the matter is altogether green, like sorrel or spinach. This greenish matter is mucus, coloured green by the colouring matters of the bile. At a later stage, of a prognosis much more disastrous, the yellow and green stools are mingled with grains of undigested milk. At times even they are wholly composed of this badly digested milk, and of white milky grains: this is a veritable lientery.

The constitution of the motions is the same as that of the physiological state; as soon as the green matter has appeared it is almost always contained in the mucus; we see in it beads of adherent mucus, tenacious, and almost transparent. There are some cases entirely made up of substances of this nature. These are cases in which the children suffer enormously. We will not enter into a discussion of the nature of this green matter. Some have thought that it was blood exuded and thrown out into the intestinal tube. This is not admissible, for we would find traces of the blood globules. It doubtless proceeds from the liver, from the colouring matter of the bile. At all times these stools are not more bilious than other stools. It is more just to distinguish them by the name of green stools; although we do not wish to discuss here if they come from the biliary colouring matters, altered or not.

The odour of the stools is an important sign to consult. In the normal state it is almost nothing. The transition stools have an acid sourish odour of sour milk. Sometimes this odour is marked and becomes penetrating; at times they are fetid and gangrenous, especially when the pathological stools contain many grains of undigested milk. It appears that this milk, not elaborated by the intestinal juices, has undergone a kind of putrefaction during its sojourn in the intestinal tube. This odour then impregnates all the bedding, clothing, &c.

It is also interesting to attend to the state of the child at the time he is passing these motions. For a normal motion, the child at first becomes pale; this is the commencement of the perception of the fecal bolus: when the expulsion effort is made the face is congested, and becomes turgid and red; the child strains, but without suffering, and he evinces a veritable satisfaction when he has unloaded the intestine. A green diarrhœa, on the contrary, is accompanied by pain, a true colic; the countenance is contracted, the features drawn, the child utters a prolonged cry, even until the exit of the fecal matters. Satisfaction then follows this pathological stool just as the normal.

We will not here take up the pathological anatomy of these stools, nor anything connected with the rest of their pathological study. Let us say only, that, however bad the stools may be, at the autopsy we find no lesion to account for them. The intestine is diseased hardly once in two or three hundred cases. We may then repeat that diarrhœa is a symptom, not a disease.

This diarrhœa, which is the effect of numerous causes, in turn becomes the cause of another alteration, of *athreptic erythema* of the new-born. This erythema (which must be distinguished from the *sudoral* erythema of little children, which is very frequent during the hot season) is a rare affection beyond the third or fourth month. It is essentially constituted in the beginning by a slight redness of the skin, which is slightly raised and crowned by a vesicle surrounded by a red areola. They are formed very rapidly by tens of thousands: then they are confounded in such a manner that we can no longer recognize the elementary lesion

save at the periphery of this patch, where we always distinguish the initial vesicle.

These vesicles appear in divers points. Let us examine them where the skin is dry—on the anterior region of the thighs for example. The redness diminishes a little, the vesicle bursts, there remains an epidermic desquamation, a whitish scale, leaving an epidermic flange and a red space. This may be observed above all on the periphery; for where the skin is the seat of a continual irritation, the grouped vesicles are confounded, the desquamation is no longer made regularly and the cuticle is removed by scratching; there only remains large red surfaces, where we can no longer recognize either vesicle or areola. It seems then that the skin is varnished; it is a brilliant red, as if its most superficial layer had been taken away.

These parts are painful, but much less so than we might think, except in cases of ulceration when syphilis must be thought of. Children attacked with erythema suffer most from intestinal colic.

Relative to its seat, erythema is found in the immense majority of cases only in certain fixed points, towards the ischiatic region of the buttocks, at the posterior and superior region of the thighs, and at times, but later, in the legs. We see then on the buttocks large red surfaces, and on the periphery small vesicles,—this is the character of erythema. However we find it at times elsewhere, on the trunk, and on the face even more frequently than on the trunk.

Erythema is not a disease having an independent existence; it is met with only in children attacked with athrepsis. Two indispensable elements are necessary for its development, an alteration of nutrition and scratching. If it were developed only by the one or the other of these elements we would find it in another seat; it would be produced on the entire surface of the body. It is never observed in healthy children: after it has appeared there is certainly a morbid trouble already present. Athrepsis may yet be present only in a very slight degree, but it already exists and threatens the child. This may then be a very useful manifestation for the physician, since the erythema appears after the beginning of the morbid evolution.

Erythema never leaves cicatrices.

This is a most important fact to know in order to make a diagnosis.

This diagnosis is not always easy. I pause to recall to you that once I mistook for this erythema the erythema of *variola*. In an analogous case, the elevated temperature, which should already be reached in the congestive period of *variola*, ought to make the diagnosis clear, for in atrepsic erythema the temperature on the contrary is hyponormal.

Sudoral erythema has not the same situation. It is especially spread over the face, neck, and trunk. It presents a less intense redness.

The vaccinal roseola is very ephemeral; it is constituted by large papules, slightly raised. There are no vesicles in it, or they are disseminated and very large. It is seldom observed but on the superiorextrimities, not often on the trunk.

We have studied the diagnosis of the *syphilides*, with which we will avoid confounding erythema. The colouration of the *syphilides*, which is always dominated by a violet tone, is very remarkable and characteristic.

Erysipelas presents large, red surfaces, swollen and œdematous.

As to the cause of this erythema we ought no longer to look upon it, with Valleix, as a manifestation always due to thrush. There may be erythema without thrush. There is no necessary connection between these two affecticns. They are frequently concomitant, because they are both a manifestation of a more general disease.

Before terminating, let us fix our attention on the *anatomical lesion* of the skin attacked with erythema. There is always in erythema, essentially and primitively, an alteration of the epidermis, and of the mucous layer of Malpighi. On the contrary, the *syphilides* always comprise alteration of the derma. There is only very rarely in erythema a slight muscular proliferation in the derma. This appears only after a very longirritation, and is then followed by a cicatrix. There is a cicatrix only when the derma has been altered; everything which attacks the epidermis alone does not produce them. This is why erythema leaves no cicatrix.—*Gaz. des Hôp.*

ACUTE RHEUMATISM—THE SALICYLATE AND ALKALINE TREATMENT OF, CONTRASTED—ABSTRACT.

BY DAVID W. FINLAY, M.D., AND R. H. LUCAS, M.R.C.S., MIDDLESEX HOSPITAL.

In estimating the effect of any drug at the bedside, it is necessary, firstly, to review a fairly large number of cases, and, in the second place, to take care that those cases are placed under similar conditions. The results we have to show are those of an analysis of 158 typical cases of acute rheumatism treated in the Middlesex Hospital—60 by salicylate of soda, 60 by the old alkaline method, and 38 by a

combination of alkalis with quinine. All of these cases, with the exception of the drug administered, were treated in a precisely similar manner, and influenced by the same surroundings.

For purposes of easy comparison we append a summary of the results arrived at in a tabular form. It should be noted that the usual dose of salicylate of soda was fifteen grains every three hours; of the alkalis, fifteen grains of the bicarbonate of potash, with a like quantity of the acetate, every 4 or 6 hours; and, of quinine, where this was regularly given, two to five grains in pill, thrice daily.

No. of cases.	Treatment.	Average duration of Pyrexia.	Average duration of joint affection.	Signs of Endo- or Pericarditis on admission.	Ditto developed under treatment.	None at any time.	Relapses.	Return of pain without Pyrexia.	Average stay in Hospital.
60	Salicylate.	5·7 days.	5·06 days.	{ 41 cases, or 68·3 per cent	7 cases, or 11·6 per cent.	12 cases, or 20 per cent.	16 cases, or 26·6 per cent.	6 cases, or 10 per cent.	} 29·7 days.
60	Alkaline.	10·3 days.	12·2 days.	{ 41 cases, or 68·3 per cent	4 cases, or 6·6 per cent.	15 cases, or 25 per cent.	5 cases, or 8·3 per cent.	4 cases, or 6·6 per cent.	
38	Alk. with quinins.	11·6 days	10·07 days.	{ 20 cases or 52·6 per cent	5 cases, or 13·1 per cent.	13 cases, or 34 per cent.	3 cases, or 7·8 per cent.	7 cases, or 18 per cent.	

REMARKS ON "PAIN IN THE SIDE."

BY EDWARD C. JANEWAY, M.D.

Pain in the side is a common enough expression on the part of the patient to a physician, and in the absence of any febrile manifestation, the patient is probably not infrequently dismissed as suffering from neuralgia, myalgia, disordered stomach or liver. What I purpose in this article is to draw attention to deeper causes which may be of light or grave import. We should never rest satisfied with the statement that the patient has neuralgia or myalgia, but should endeavour to ascertain the hidden source. Hence it is necessary to examine carefully the site and limitations of the pain, as well as the conditions which bring it into play. I believe that it is a wise plan to cause every male patient so complaining to strip to the waist, in order that a more critical examination may be made, and to do the same for the other sex with the exception of a light dressing sack or a chemise. We are thus prepared for a careful exploration of the lungs if that should be necessary. Next let the patient define the site of the pain, and if it is brought about by any special motion, let this be illustrated as far as practicable. We should study the position which the individual is in the habit of assuming in any occupation at which he may be engaged. If we find that a patient has the three tender points which are characteristic of intercostal neuralgia, we must avoid stopping there. The questions to be decided are: Is this due to some injurious influence affecting the body, as the malarial poison, lead, insufficient nutrition, brought about by dyspepsia, too little food; or excessive discharges, as prolonged lactation, abuse of sexual function, diabetes, etc.; or by some alteration of fluids by disease, as in gout, Bright's disease. Or on the other hand, is it due to some local cause, as an aneurism, Pott's disease, gummy growth or some form of tumour compressing the nerves within or without the spinal canal. It may seem to some of the readers that I have unnecessarily extended the list of conditions to be thought of when examining a patient, but I have in reality fallen short, for I have left out of account affections of the spinal cord itself, which usually produce

double-sided or girdle pain. So also it may be claimed do aneurism and Pott's disease. I have, however, within the last month seen three cases which illustrate the necessity for this care with reference to these diseases. The first had been treated for six months for intercostal and cervical brachial neuralgia, which an examination showed to be due to an aneurism of the transverse arch pressing upwards behind (?) the innominate artery.

The second had Pott's disease but had been treated for four months for intercostal neuralgia, and disordered liver; the pain being in the lower intercostal nerves and particularly on the right side. An examination of the back revealed a marked angular projection in the lower dorsal spine. These two of recent date will perhaps suffice, but I could strengthen the position by reference to a number of cases of aneurism and some of Pott's disease which had been overlooked, the pain being considered as indicative of neuralgia only. But to show the necessity for a careful examination still more strongly, it would simply be necessary to refer to histories of patients with leucocythæmia of splenic type. Pain in the left side has been in several cases that have come under my observation, the first symptom of the disease, and as far as the patients' words can be relied on, they had been under treatment for neuralgia or some other disease which might be productive of pain in the left side. A corollary from this would be that with pain in the left side in the region of the spleen, a microscopic examination of the blood might give an early revelation of a disease which is usually recognized at a date too late for any material benefit to the patient. For those who are not in the habit of making this examination I would state, that all that it is necessary to do is to prick the finger, previously pressed below, with a sharp needle or pin, receive the drop on the cover, and transfer this immediately to the slide, and examine with the microscope for excess of white globules. But let us suppose that we have excluded anything like aneurism, Pott's disease, or leucocythæmia. We will still have to consider the possibility of a sub-acute pleurisy. I recall at this moment the case of a physician consulting me about pain in the left side, in whom a careful exam-

ination failed to reveal the cause for a neuralgia, yet three days later the physical evidences of pleurisy were manifest. At this early stage then we may have pain only with characteristics of neuralgia or pleurodynia, and that without fever; for in the case I mention, the temperature carefully taken was $98\frac{1}{4}^{\circ}$ F. The obvious inference from such an example is that it is wise to re-examine in all doubtful cases. But pleurisy causes pain in the side not only in its earlier but also in its later stages where firm adhesions have formed and the nerves are implicated in the thickened pleura. So that we are obliged to think of this latter possibility also. Perhaps it is more common for people to imagine that they have phthisis because of a pain in the side than for phthisical patients to have pain in the side as the most prominent symptom, yet I can recall some cases in which I have discovered phthisis when the patient had come to me simply out of sorts and troubled with a pain in the side. Such a case of quite remarkable character I saw quite recently in a gentleman who consulted me about a pain in his side which he supposed was of little moment, and neuralgic. The whole right lung was useless to the patient, the pleura thickened, and the lung indurated. I could scarcely convince the gentleman that there was anything special the matter with his chest. Such cough as he had he imagined due to a nasopharyngeal catarrh. This is of course a prominent illustration, but minor grades are by no means infrequent. So also with heart disease, many more people imagine that they have it on account of some pain in the left side than are found to be victims of the malady, having been examined by a physician in consequence of such pain. Yet the examination of the heart is so easily performed that it is wise to include it in our search. We should also question the patient with reference to the urine if we do not make an examination of it. Judging from the number of times which I have found a spleen adherent to the diaphragm and its capsule thickened, I believe that this is at times a cause of obscure pains in the left side. I have thus far examined in vain cases which I thought were possibly of this nature for a perisplenic friction sound. The only conditions under

which I have heard friction sound over the spleen have been when the organ has been considerably enlarged, and I am doubtful whether it is possible to hear a friction sound due to roughening of the capsule of a normal sized spleen. There is an occasion for pain on the right side of an obscure character, which I believe to be entirely overlooked. I have seen a number of cases at the post mortem table in which I felt that the strong probability was that they had experienced obscure pain in the region of the lower border of the liver in the neighbourhood of the gall bladder. In these cases I have noticed adhesions of the gall bladder by peritoneal folds to the colon or duodenum, usually without any evidence that such folds were of inflammatory origin, but rather developmental. Last week such a one came under my notice where the adhesion was to the transverse colon on its upper and anterior portion, and a slight traction on the intestine served to stretch the gall bladder. I suppose that it has fallen to the lot of the majority of practitioners to be consulted about dragging pains in this vicinity, which they were unable to explain, and I offer this as an excuse for a certain number. I have made such diagnosis on several occasions, and have seen no reason to regret it. The fact is, I do not see how pain could have been well avoided in some of these cases during active peristaltic movement.

As my intention, announced at the beginning of the article, was simply to draw attention to causes for pain in the side that might be overlooked, and which experience has showed me were overlooked, I desire the reader to consider this fragment in this light. That other causes exist for pain in the side I am aware, but a short journal article is hardly the place for their full consideration.—*Hospital Gazette*.

METALLO-THERAPY.—Prof. Charcot is said to have greatly modified his views on this subject. Dr. Yandell, writing to the *Louisville Medical News*, mentions that Prof. Charcot had said to him that he did not deem metallo-therapy of any practical value, but that it was a curious subject well worthy of study.

ON BENZOATE OF SODA IN DIPHTHERIA.

Letzerich says, (*Berl. Klin. Woch.*, No. 1, 1879) that he has repeatedly given this drug in diphtheria, and has always found it to answer very well. He attributes his success to the antiseptic properties of the drug, by which the development of the diphtheritic bacteria is arrested. He also points out that it is a most effective remedy in infantile, gastric, and intestinal catarrh, and in mycotic (fungous) catarrh of the bladder. In short he fully corroborates Professor Klebs' statement when he says that in Benzoate of soda we possess a very powerful remedy in all affections arising from the presence of contagious matter in the system. The following is the author's method of administering the drug: R. Natr. benz. pur., 5 grammes, solve in aquæ destillat., aq. menth. pip., āā 40 grammes; syr. cort. aur., 10 grammes. Infants under one year were given a desertspoonful every hour. Children from one to three years old must take a larger dose, viz., a tablespoonful every hour, the proportion of the benzoate of soda being also increased from 5 to 7 or 8 grammes. To patients from three to seven years old, 8 to 10 grammes are given; to those over seven, from 10 to 15 grammes. Adults should take from 15 to 25 grammes in the same solution, the proportion of the solvents and the syrup remaining the same. The diphtheritic membranes were powdered with benzoate of soda, in severe cases once in three hours; in lighter cases, from two to three times daily. A solution of the strength of 5 per cent. forms a very efficient gargle for older children.—*Lond. Med. Record.*

PASS AND PLUCK.—From the annual report which has just been published by the Council of the Royal College of Surgeons of the number of candidates who have presented themselves before the board of examiners in Anatomy and Physiology during the collegiate year 1878-79, it appears that, out of 785 examined, 530 were successful, and 255 rejected. At the Court of Examiners during the same period, 509 were examined, of which number 345 received their diplomas of membership, and 164 were rejected.

BANDAGING IN MIGRAINE.—Dr. Weir Mitchell (in the *Boston Medical and Surgical Journal*), relating a case of migraine occurring in a girl seven years and a half old, exhibiting the congestive type, and for which he prescribed small doses of bromide (gr. iij.) and tinct. belladonnæ (gtt. iij.), observes that the use of the old domestic remedy, a tight bandage, during the attack, is useful. He employs a rubber bandage, applied thoroughly from the eyes up, with a thin pad over each temporal artery, if the temporal ridge be sharp enough to keep the bandage from squeezing the arteries, and over the two occipital vessels. Instead of caoutchouc, a well-applied muslin bandage may be put on, and then wetted, using compresses over the temporal arteries. The comfort thus given is sometimes surprising. He adds, "I need not say that migraine in some of its forms becomes at times—and especially in women—a most disabling malady, and may recur daily until life is a burden impatiently borne. These are usually cases of thin-blooded and thin people, whose sufferings are brought back by the attempt to take exercise, without an abundance of which a return to health is out of the question. I have seen some such cases in which a cure little less than marvellous has been made by the use of absolute rest, over-feeding, and massage. There is, of course, much more to be said on the therapeutics of megrim, but no one drug is its master. The hint as to thorough bandaging is worth remembering, and especially at the close of a headache."

A little French girl was greatly frightened during a late thunder storm, and for a time her parents had their fears awakened as to her recovery from the shock. The electric fluid, it seems, passed very close to her. For a moment she seemed to be suffocating, but the sensation soon passed off into a fit of hiccoughs. These became so distressing that after three days her mother took her to the Children's Hospital in Paris for advice. The surgeon ordered her to the operating theatre, where, on seeing the medical man standing at a table covered with some awful looking instruments and surrounded by a number of assistants in white aprons, the child became so terrified that she forgot her hiccough, and she was thus cured.

Surgery.

CLINICAL LECTURE ON MALIGNANT STRICTURE OF THE HEPATIC FLEXURE OF THE COLON.

BY JAMES F. GOODHART, M.D.

Assistant Physician to Guy's Hospital and the Evelina Hospital for Children.

The case to which I invite your attention, gentlemen, to-day is one of stricture of the colon; but, in order that those of you who know little about such things may follow me the more readily, it will be advisable, in the first place, to mention the common symptoms of intestinal obstruction, and also the various causes of the same.

The symptoms are vomiting; griping abdominal pain; constipation; more or less distension of the abdomen; abnormally visible peristaltic action of the bowels; and possibly, in some cases, diminished quantity of urine.

According as the obstruction is sudden and complete, or slow and for a long time incomplete, in its onset, you can readily understand that the symptoms will be likely to differ. Thus, in sudden cases, the vomiting and constipation are immediate, and the abdominal distension follows soon after. In the chronic cases, there is usually a history of paroxysmal colic for some time before the outset of more urgent symptoms. The abdominal distension slowly increases, and reaches an extreme degree, and the vomiting and absolute constipation come on at this late period. Moreover, throughout the illness, the visible muscular action is usually a prominent symptom. This is, I think, the simplest division of intestinal obstruction—into acute and chronic; and you will find that the various forms are readily classified in this way for clinical interpretation. It is not very elaborate, and therefore proportionately liable to error for exceptional cases; but it is correct for the majority of cases. Some writers attempt to classify according to the seat of the disease; this comes very much to the same thing, but is not quite so simple.

The following causes are usually enumerated:

1. Plugging of the intestine by foreign bodies and concretions.

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|-------------------|---|----------------------------|
| Acute. | } | 2. Internal strangulation. |
| | | 3. Volvulus. |
| Acute or Chronic. | } | 4. Intussusception. |
| Chronic. | } | 5. Contractions. |
| | | 6. Strictures. |

Of these six, the first, except when due to a large gall-stone, is very rare, so that need not detain us. Nos. 2 and 3 are associated with very acute symptoms, early vomiting, pain, and distension of the abdomen. Intussusception occupies a somewhat intermediate position, as it is sometimes acute, sometimes chronic; and five and six have usually chronic symptoms.

The case is that of a man aged 27, admitted into the clinical ward on May 22nd, 1878, and who died on May 31st. He was an Irishman, born in Killarney, and had had no illness that he was aware of, with the exception of measles, and, four years ago, of gonorrhœa. His father and mother are alive and healthy. He has drunk very freely of spirits and beer, being for some time a bottler of whiskey, when he used to imbibe more than half a pint *per diem*. From Killarney, he went to a sugar-factory at Bristol, where he used to drink considerably more than three quarts of beer in the day. During the last twelve months, he has not drunk nearly so much, only taking spirits at long intervals, and about a quart of beer per day. During the last nine months, the patient has suffered from attacks of griping pain in his right side, more especially after taking beer; he has never noticed that the pain was increased by food; and he has been so little troubled by it as to take not much notice of it.

About two months ago, he caught a bad cold, and was confined to his bed, and treated by a medical man. He then first noticed a hard swelling in his right side, just below the ribs. Previously, he had felt in good health, and had been able to work and eat well. He now began to have pain in this spot; and, though he got better of his cold, and began to work again, he felt weak, and his appetite failed. A month ago, he was seized with severe pain in his right side, and for two days his bowels were confined. This attack passed off, but only to be succeeded by another in a

week's time. The pains generally came on in the evening, and, after lasting twenty-four or thirty-six hours, would go away. During the pain, he was always sick, and, in so doing, was relieved. The vomit was bilious, green or yellow. Sickness never came on immediately after food, nor has he ever thrown up any blood, but the ejecta have been of the nature of coffee-grounds. The vomiting has only existed for the last four weeks. The bowels have been irregular, at one time constipated, at another loose. The motions have lately been very black. He thinks he has wasted in the last three weeks. He has been able to take solid food till the last week, but since then has kept to milk and brandy.

When admitted, he is described by my clerk, Mr. Malpas, as of a dark sallow complexion, slightly jaundiced, with worn, pained, and somewhat pinched-looking face. He lies in bed on his back, with his legs drawn up; this being his most easy position. His tongue was furred and moist. He was always thirsty, but quite without appetite. The bowels had acted not long before he came in.

The abdomen was not at all distended—rather the reverse; so much so, that a tumour now to be described gave a slight prominence to the surface immediately over it. It occupied the right hypochondrium and right umbilical region, extending for an inch below the umbilicus. Its lower edge was well defined, but not its upper; the whole mass very tender and very hard. It was comparatively dull, but yet distinctly resonant on percussion, and between it and the right rib there was very distinct resonance; above this, came the hepatic dulness as usual, extending half a space higher than its normal limit. The swelling moved but very little, if at all, during deep inspiration. The pain came on in paroxysms, and, during them, the tumour became visibly more rounded, but there was no visible peristalsis. All the viscera seemed normal, and the temperature was normal. There was no ascites; no jaundice worth the name; no enlargement of the surface veins.

These, gentlemen, are details of this case, wanting only that which no description can give—the something over and above the mere

symptom which the eye takes in at once, and which is often all-important in making the diagnosis. However, I do not know that there was anything very striking in this man's appearance except that he was very pale, and looked proportionately ill. Will any one suggest a diagnosis?

Well, first of all, what may the symptoms indicate? A hard, somewhat nodulated lump between the umbilicus and the right ribs. In that region are the liver, gall-bladder, pylorus, head of the pancreas, the hepatic flexure of the colon, and, behind these, the suprarenal capsule and kidney, and some lumbar glands; and, lastly, mesentery and omentum may be displaced anywhere, and therefore must be mentioned. Bear in mind, too, that spinal curvature—lordosis, as this form is called—will sometimes so push forward the pancreas and aorta as to simulate an abdominal tumour or aneurism. To remember this is to make your diagnosis so far as it is concerned; because it is, of course, easy to examine the length of the spine; and, when there is curvature of one part, there is nearly always curvature of another part compensatory. This patient had no spinal curvature.

Then to take the other possibles *seriatim*. Had he any liver-affection? What liver diseases are liable to occur in a young man of twenty-seven? First, there is hydatid disease, which has these features: that the tumour is cystic; that, therefore, it gives the physical signs of fluid, viz., a thrill—in some cases, a peculiar thrill—and the globular elastic tumour, generally speaking, bulging well into the right hypochondrium. It is a swelling comparatively free from pain. It is associated with little or no disturbance of the health. These are conditions, you will observe, which do not tally with those in this case. The tumour was not cystic, but very hard and unyielding. It was not even globular; nor did it occupy the region of a hepatic cyst; and, instead of being unassociated with disturbed health, the man, as I have told you, was evidently very ill. In these latter points, however, it might agree with the symptoms of hepatic abscess or suppurating hydatid; but then, again, these would give the same cystic

bulging of the liver if they gave any sign ; and it was not present. Then some syphilitic disease of the liver—was it that ? Syphilis leads to the formation of large hard masses in the liver, which produce much matting of the surrounding parts, and therefore occasionally give rise to a good deal of pain ; so that it might have been something of that kind, even though there were no other traces or history of anything of the kind. And, lastly, was it any malignant growth in the liver ? Well, that is so exceedingly uncommon as a primary disease in anybody ; and in a young adult of twenty-seven still more so, that any opinion of that sort was mentioned only to be dismissed. So, then, of all the possible affections in the liver, we have only one left, viz., some gummatous inflammation. But I did not think it was a mass connected with the liver at all ; first, because the tumour itself was distinctly resonant ; and, secondly, because there was still more marked resonance between the lump and the ribs, above the margins of which came the normal hepatic dulness in due course. You occasionally find a large liver coming some way below the ribs, overlapped by or covered by some intestine ; so, that, though really enlarged, the abdominal portion is hidden ; but I never saw a liver covered above by intestine and protruding below ; and, if you think a minute, such a condition is hardly possible considering the relation of the intestine to its mesentery. Such a condition is just possible with regard to the gall-bladder ; that the coils of intestine might enfold that viscus, and become adherent round it, giving resonance above it, and some transmitted resonance over it ; and the gall-bladder is rather liable to set up inflammation round it, and fever. It becomes over-distended, and inflamed because over-distended. But I did not much think this was gall-bladder, because distension of the gall-bladder in young people is usually associated with some jaundice, and this was not ; for though Mr. Malpas tells you the man was jaundiced, I think it would have been more correct to leave the earlier report, that the complexion was *sallow*, without the addition. He was *sallow* no more. Then, too, the fundus of a distended gall-bladder is not often adher-

ent to the surface to such an extent as to produce a lump so defined as this was. It is a pyriform elastic swelling, to be felt only with care. Then, too, both liver and gall-bladder descend freely during inspiration ; this tumour did not ; though of course that symptom is liable to be modified by adhesion, should this have occurred.

Then we may take kidney and suprarenal capsule ; and I may at once lay down this rule, that, unless very large or abnormally mobile, enlargements of these viscera do not produce any well-defined tumour so superficial as this was. A man may have twenty or thirty ounces of kidney in each loin, instead of four or five ; and, unless there be any special renal symptoms, the tumours will very probably not be detected. This is because they are behind all the coils of intestine, and push these forward, so that the swelling is masked in this way. Renal tumours are indicated by a general fulness of the abdomen, or ill-defined resistance in either lion ; and then, on careful manipulation, you will get fluctuation and so on. Now go and verify this for yourselves in the case of 19 in Philip ward. There is a man who has had symptoms of renal calculus on the right side. Go and examine his abdomen ; and you will have learnt a lesson you will not forget. The same thing applies to the suprarenal capsule, though less generally, because growths in it of any size are apt to push forwards towards the median line, and may appear as definite tumours well defined, by pushing up the pancreas in front of them. As an outside chance, I put down tumour of the suprarenal capsule.

We have now left the pyloric region of the stomach and colon, omentum, and mesentery. The pancreas may be left out of the question, because I might say the same of it as Sir William Gull used to say here of the jejunum, "that it has no pathology." That is a fact, though worth your thought. Sir W. Gull used, I say, to take the ileum, jejunum, and duodenum, and enumerate the disease of the first and the last, and find nothing to score against the jejunum. That is so ; the jejunum is but rarely diseased primarily ; and what is true of the jejunum is true of the pancreas, so far as we

know at present ; its diseases are not numerous. As between the remaining possibilities, I said this: First, that the paroxysmal griping pain associated with vomiting that this patient suffered, and also the visible swelling of the abdomen which occurred at the seat of the tumour, together with the resonance over the tumour, were proof of some matting of the intestine, and so an impediment to its healthy painless muscular action, or else of some positive obstruction. There was, however, no distension of the abdomen, and the bowels, though not regular, were not confined ; so I thought there could be no obstruction of anything more than a temporary kind ; and under such circumstances, intussusception or any malignant disease of the colon were hardly likely. I therefore turned to the stomach, the patient being a young man, and a former hard-drinker and suggested that he had some ulcer there, which had, as do so many gastric ulcers, slowly perforated into the tissues outside ; making its way downwards and to the right, instead of backwards ; and that the inflammatory thickening so set up, had caught the intestine, and led to the paroxysmal colic. That was my diagnosis ; but, in making it, I had to do some violence to two sets of facts. The first was remarked upon by some of you, viz., that the man had no symptoms of gastric ulcer. To this I replied, that gastric ulcer gives so few symptoms in many cases, that the absence of them is not to be relied upon, especially in hospital patients, who take so little heed of their symptoms ; and, moreover, this man had had " coffee-grounds " vomit, and passed black stools—very like gastric hæmorrhage. Secondly, the swelling in the abdomen was so hard, that I was strongly disposed to think it must be a new growth of some kind ; and I also remarked that you must bear in mind that growths in the stomach and intestine do occur at earlier ages than most other growths ; and I mentioned the case of a woman which is on record, where carcinoma of the stomach caused death at twenty-one.

Closer than that there was no ground for going ; and, upon that diagnosis, and the prominent symptom being the one of paroxysmal colic, we gave him half a grain of opium three

times a day, and kept him on milk diet, hoping that by this means the muscular coat of his intestine would go to sleep, and let the supposed ulcer or inflammation subside. Unfortunately, he was already, only we could not see it, in a hopeless condition ; but let me continue the report of the case.

(To be continued.)

SUPERFLUOUS HAIR.—SIR, In answer to your correspondent " Medicus," as to the treatment for removal of superfluous hair from the face and hands, I made the same inquiry, after repeated trials of various treatment, and the use of all the well-known depilatories, in an obstinate case of general hirsuties. I find that, if the growth be localised and the hairs few, the best method is to remove each hair by the tweezers, and to insert a three-sided needle into the follicle, completely destroying it, as suggested by Dr. Bulkley in the *Archives of Dermatology* (New York, October 1878, vol. xiv., p. 4). If the hair be general and over large surfaces, a preparation of liquor potassa and spirits of wine in equal parts carefully brushed over the affected parts twice a-week, and the parts to be well washed afterwards, say with Pears's soap. This method has proved most successful in a series of cases in which I have applied it. This method was mentioned also by Dr. Cairns Wicks, in the *British Medical Journal* of July 26th last.—I am, sir, yours truly, JAMES STARTIN, Surgeon to St. John's Hospital for Skin-Diseases.

SUPRA-PUBIC LITHOTOMY.—1. In children supra-pubic lithotomy is preferable to all other methods of operating. (2.) In adults, supra-pubic lithotomy will be found very useful in many cases. (3.) A catheter must never be allowed to remain in the bladder after the operation. (4.) The vesical suture, which has been recommended by Latzbeck and others, after supra-pubic lithotomy, ought to be applied if possible. In this case dressing the wound must be treated strictly antiseptically. (5.) Much importance not to be attached to statistics which seem to prove that lithotripsy is preferable to lithotomy.—(Prof. L. E. Van Goedeveer.)

PSORIASIS PALMARIS.

I can corroborate, from my own experience, the statement made in the *Journal* of June 7th by Dr. McCall Anderson, that there are three affections of the palms and soles which closely resemble each other, viz., eczema rimosum, simple psoriasis palmaris, and the so-called syphilitic psoriasis palmaris, and that, therefore, no absolute statement can be made, as Dr. Spencer suggests, that "there is no such thing as psoriasis palmaris except as a syphilitide," although everyone will agree that simple psoriasis of the palm is exceptional. With regard to the syphilitic affection, there is one diagnostic point that has not been alluded to in the *Journal*, which is often a help in doubtful cases; and that is, that the syphilitide almost invariably begins in the centre of the palm, while the two diseases which so closely resemble it do not, as a rule. Even here, however, no absolute statement can be made. I have a patient at the present time attending the skin department of University College Hospital, with well marked simple psoriasis affecting the trunk and usual situations; and, since he has been under treatment, a thickened, scaly condition appeared on the ball of the thumb close to the centre of the palm, which has yielded to a strong application of cantharides. The patient is a robust, healthy-looking young man, without the least evidence of syphilis, and there were no patches of psoriasis on other parts of the hand. Two years ago, a man was attending the skin department with an eruption upon the palms of the hands, consisting of circular well-defined patches about one-third of an inch in diameter, covered with fine silvery scales. There were one or two on the sides and backs of the fingers, but none elsewhere. Similar spots on other parts of the body would have been unhesitatingly pronounced to be psoriasis, and the eruption was not at all like its syphilitic namesake. He had had several previous attacks, always on the hands; strenuously denied syphilis, about which he had had previous inquiries, and the eruption was cured by treatment suitable for simple psoriasis.—H. RADCLIFFE CROCKER, M.D.

In reference to Drs. Spender's, Liveing's, and McCall Anderson's very instructive papers on psoriasis palmaris, I may state that I am in the habit of recognizing five distinct diseases that are wont to occur on the palm or sole without other parts being necessarily simultaneously involved, and which may present a not very dissimilar appearance—namely, eczema, psoriasis, syphilis, lichen ruber, and erythematous lupus. I have frequently met with psoriasis in this situation as part of the general non-syphilitic disease, often in gouty subjects, and with no co-existing eczema. There is also a form of palmar psoriasis, to which the late Mr. Nayler first called my attention, and which, for the sake of distinction, he was in the habit of designating "non-specific palmar psoriasis." In these cases, the skin of the whole palmar surface of the hand, fingers, and thumb is red, thickened, and hard, and the natural furrows of the skin occupied by small white scales, so that the whole surface is mapped out with fine white lines. No cracks nor fissures are present; and the part is always dry and harsh, and generally hot and irritable. The condition may exist with or without psoriasis in other situations, and nearly always occurs in women. I lately saw a typical case. A girl, a teacher in a school, was admitted at the Hospital for Diseases of the Skin with psoriasis of the nails of both hands, and a few patches of the same complaint on the arms, the palmar aspects of whose hands were affected as described. The eruption in all parts had always been dry and scaly, and had existed two years. A rash which, by the patient's description, was probably psoriasis, had shown itself at intervals in other parts from an early age. There was no history of syphilis. Though in lichen ruber it is unusual to find the eruption only on the palms of the hands, I have seen it fade and disappear in other parts, while some evidences of it have remained on the palms.—WYNDHAM COTTLE, M.B., F.R.C.S., Savile Row.

In hospital practice, I see numerous cases of all three varieties—namely, eczema palmaris, psoriasis palmaris, and syphilitic psoriasis. The differential diagnosis seems to me most easily made by the following characteristics:

Syphilitic palmar psoriasis may be diagnosed :

1. By its certain syphilitic constitutional history ; 2. By the circumscribed appearance usually assumed in this eruption ; 3. By the minute pearly glistening nature of the epidermic scales over a bright circus on the face : 4. By its obstinate duration unless specifically treated.

Psoriasis palmaris simplex is distinguished :

1. By its non-specific history ; 2. By its more diffuse characters and non-symmetrical appearance ; 3. By the split nature of the surrounding epidermis, and general desquamation of the skin ; 4. By being usually referred to some habitual mechanical or chemical irritation, as in the case of barmen and others.

Eczema palmare is distinguished: 1. By its superficial desquamation, often accompanied by moisture, a distinctive sign of eczema ; 2. By its almost invariable occurrence with gouty or rheumatic diathesis ; 3. By its being amenable to treatment for the above-named affections, chiefly alkaline, and its non-influence by specific treatment.

One case nearly identical with that quoted by Dr. Anderson more especially occurs to me. A clergyman consulted me last year. He had been suffering for some years with a squamous affection of the palms of the hands. I prescribed the different preparations of mercury and tar, but with little or no avail. Vaseline and acetate of lead were most beneficial, as I have found in all these gouty skin eruptions, combined with suitable constitutional treatment and dieting, without the use of stimulants, especially beer and alcoholic liquors, a poison to most skin-affections. He is now visiting the alkaline springs of Switzerland, from which, he informs me, he is getting much benefit.—JAMES STARTIN, Surgeon to St. John's Hospital for Skin-Diseases ; Savile Row.—*Brit. Med. Journal*.

TO POSTPONE THE FINAL MOMENT.—Under the above heading, in the *St. Louis Clinical Record*, mention is made of a case of phthisis in which the patient, a young woman, was in extremis—extremities cold, radial pulse gone, respiration gasping, and tracheal râles evident to everyone in the room. Three drops of amyl nitrite were given by inhalation. The pulse returned to the wrist, the face showed some colour, the respiration became more free and lost its stertorous character, ability to swallow and to speak returned. This lasted an hour, when depression returned. The amyl was used again and again with less and less effect, till, finally, it ceased to act.

Midwifery.

HÆMORRHAGE FROM THE GENITAL ORGANS DURING PREGNANCY AND PARTURITION.

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The President (Dr. Kidd) said that, before calling on Dr. Macan to close the debate, he would sum up some of the more important points that had been touched upon, with a few brief comments. Dr. Macan opened his paper with remarks on the hæmorrhages of the early months, and the so-called menstruation of pregnancy, which he had very conclusively shown was not menstruation at all, but hæmorrhage arising from various causes ; and Dr. Henry Bennet had drawn attention to the frequency of inflammation of the cervix as one of these causes. This was quite in accordance with his (Dr. Kidd's) own experience ; and, guided by what Dr. Bennet had said in his work on *Inflammation of the Uterus*, he had from an early period made it a rule, in treating cases of frequently recurring small hæmorrhages, or long continued draining of blood in early pregnancy, to examine the cervix, when he generally found the condition described by Dr. Bennet ; and on curing this the hæmorrhage ceased, and the patient went to her full time. Dr. Macan said he had directed attention to the recent use of the thermometer as a means of ascertaining whether the embryo was still alive or had perished. If the thermometer could afford positive information on this point, it would render the obstetrician even greater service than it had conferred on the physician in the treatment of typhoid fever ; but we must still rely on the old rules of practice, and endeavour, when the os was not open and no portion of the ovum protruded, to prevent abortion ; and when it was open and a portion beginning to protrude, use all the means in our power to hasten its expulsion. Plugging the vagina was a most valuable method of controlling the hæmorrhage ; but so long as there was any hope of preventing the abortion, no attempt should be made to adopt Dr. Bennet's suggestion of plugging the os. It was even doubtful whether the vagina should be plugged under such circumstances, unless the hæmorrhage were excessive. When the em-

bryo had come away and the membranes remained, plugging was a most valuable means of treatment in the early months. This was a most perplexing condition; so long as the membranes were retained, the patient was liable to excessive or even fatal hæmorrhage at any moment, and they might be retained for days; but if the vagina were sufficiently plugged, more especially if Dr. Bennet's form of plugging the os, "bottling up the uterus," as he called it, were adopted, the attendant might leave his patient for some hours, satisfied that no hæmorrhage of consequence could take place; and when he removed the plug at the end of ten or twelve hours, he would probably find the membranes in the vagina and all risk of hæmorrhage over. Another plan that had been often adopted, especially when the membranes had not come away with the first plug and the os was open, was to pass a catheter into the uterus, and with a syringe throw up a stream of cold water. This generally caused their expulsion in a few minutes, and he had never seen any unpleasant consequence arise from the injection. Placenta prævia was the next subject referred to. He would only allude to the very interesting points as to the pathology of this condition, discussed by Dr. Macan and Dr. Barnes, and would pass on to some of the plans of treatment spoken of by others. Dr. Wallace spoke of plugging the vagina as being in common use in Liverpool, and expressed fear of the practice, lest the hæmorrhage should go on in a concealed manner, blood accumulating in the uterus. Plugging had long been the practice adopted in Dublin, but it did not originate there. It was a German practice introduced in the last century; and when the membranes were unruptured, or the case was one of complete placenta prævia, it was a most remarkable method of controlling hæmorrhage till the os was sufficiently dilated to allow the completion of labour. If the placenta were attached all round the os internum, or the membranes were unbroken, the blood could not accumulate in the uterus. But the plugging was not so much in use in Dublin now as formerly. Twelve or fourteen years ago, there was a great debate in the London Obstetrical Society on the treatment of placenta prævia; and since

the induction of labour as soon as possible after the discovery of the nature of the case, especially if the child were viable, had been more and more adopted as the rule of practice. He had himself been frequently called to see patients who had been safely conducted through one or two early and slight hæmorrhages, and then reduced to a state of so great prostration by a sudden rush of blood that they died in the act of delivery, or even before it was attempted, and therefore he lost no opportunity of urging the induction of labour as soon as it was clearly ascertained that the case was one of placenta prævia. For this purpose the plugging of the os after Dr. Bennet's plan, with prepared sponge, as suggested by Dr. Playfair, was the best means of commencing the induction of labour, as not only checking the bleeding, but at the same time dilating the os. Regarding the treatment of *post partum* hæmorrhage, Dr. Edis had drawn attention to the preventive treatment, and to the advantage of attending to the general health of the patient before labour came on. He had happily compared this to the training an athlete underwent before undertaking a race or other great physical exertion, and had very wisely urged that women should be put in training by attention to their general health for the exertion they were about to undergo. Dr. Malins, Dr. Dill, Dr. Edis, and others, had further spoken of the importance of preventing the woman's powers from being worn out and exhausted by prolonged efforts in labour, and advised that she should be assisted by the use of ergot or by the forceps. That the undue prolongation of labour was one of the most frequent causes of *post partum* hæmorrhage could not be questioned, and all must agree with Dr. Edis in recommending the prompt use of the forceps when delay threatening to exhaust the patient occurred in the second stage. There was another means of preventing hæmorrhage which had not been spoken of, that was of not less value: the placing of the hand on the fundus as soon as the child's head was expelled, and following the uterus down, keeping it contracted till not only the placenta was expelled, but for some time afterwards, to afford time for the closing of the vessels by Nature's own processes. This following

down of the uterus was called by Dr. Collins "a duty of paramount importance," and was very different from the method of Crèdè, which had been mentioned. He tried to expel the placenta at once by pressing on the uterus. Collins' or the Dublin method was to wait till the uterus expelled the placenta by its own efforts, securing a good contraction all the time; and with the same reason one did not extract the child, but allowed it to be expelled, even the feet, by the contractions of the uterus and vagina. The introduction of the hand into the uterus for the removal of clots, and causing contraction, as a means of checking hæmorrhage, had not been spoken of. It was certainly a most efficient mode of treatment, and should always precede the use of injections of any kind. Though an operation that seemed specially liable to be followed by inflammatory and septicæmic symptoms, it was certainly not so dangerous as the use of styptic, or perhaps even simple injections, and in the majority of cases completely checked the bleeding. Dr. Malins spoke of the effect of vomiting in checking the bleeding, and reminded the meeting of Higginbottom's recommendation to administer ipecacuanha in cases of *post partum* hæmorrhage. Of this treatment, the President had no experience; he had not tried it, because, in the first place, ipecacuanha took a considerable time to produce its effects, and he feared the nausea that preceded the vomiting would be injurious; but he was always glad to see vomiting in cases of hæmorrhage, and more than suspected that the greatest benefit derived from the use of ergot by the mouth was caused by the vomiting it often induced. He had very seldom seen hæmorrhage recur after vomiting had taken place. Dr. Walter's cases proved that the conditions were not yet known, under which injection of hot water might be relied on for inducing contraction and checking bleeding. That it was often useful, and stimulated very promptly the vital powers when the patient was cold and prostrate, the President was well aware from his own experience. The injection of a solution of perchloride of iron acted in a different way. The iron both coagulated the blood and corrugated the uterus, as Dr. Barnes had remarked. Unfortunately the coagulation sometimes extended along the vessels, even reaching the heart, and so killing the patient. In Coombe Lying-in Hospital, they had often tried the introduction of a small piece of the solid perchloride into the uterus, either leaving it there or removing it in a few seconds; and the practice was probably a safer one than the injection of a solution. Professor Dill and Dr.

Cordes had spoken of the advantage of lowering the patient's head so as to favour the flow to the brain of any blood that might still be in the vessels; bandaging the abdomen, by compressing the vena cava and other large veins, contributed to the same effect. Not only should the pillow and bolster be removed, but the foot of the bed should be elevated so as to give a decided inclination to the blood to gravitate towards the head. Some years ago, Dr. Wyse, of Rostellan, in the county Cork, wrote a paper recommending that the arms and legs should be elevated almost to a right angle with the body for the same purpose; and more recently German writers suggested bandaging the limbs tightly with the same view, and dignified the process with name of "autotransfusion." The last resource was transfusion. Dr. More Madden spoke of this as a difficult operation; but after experience of it, the President could state that with due care, and following the method and directions of Dr. Robert McDonnell, it was not very difficult. He believed that it was almost entirely devoid of danger or bad after-consequences, and one that ought to be had recourse to at a much earlier stage than had hitherto been done.—*Obstetric Section, British Medical Association.*

VOMITING OF PREGNANCY.

In his recent work on "Physiological Therapeutics," Dr. Poole suggests a new theory of the cause of vomiting in pregnancy, in accordance with his general view of the antagonism between nerve and muscle. It is, that the rapid development going on in the uterus monopolizes so much of the available nerve force of the organism, that the nerves of the stomach suffer a deprivation, and their *restraining* power over the gastric muscle (the stomach) being consequently enfeebled, the independent contractile power of the muscular walls of that viscus, no longer adequately controlled, produces more or less frequent irregular and excessive contractions ejecting its contents: the frequency or rarity of this result depending on the relative strength of the antagonistic forces acting respectively through the nerves and muscle.

Vomiting in general is held by Dr. Poole to depend on paralysis of some portion of the nervous circle connecting the brain with the stomach, and of course emetics are paralyzers: certainly few if any of them can fairly be regarded as stimulants. If this view of the cause of the vomiting of pregnancy be correct, remedies producing decidedly "sedative" effects ought to be avoided, and the treatment directed by hygienic and other measures, mental and physical, to attract an increased supply of nerve-force to the gastric nerves.—*Cor.*

Original Communications.

HYPERTROPHY OF THE PROSTATE.

BY A. H. WRIGHT, B.A., M.B., M.R.C.S., ENG.

Read before the Toronto Medical Society, September 25th.

Old age is honourable; so they say, but it is inflicted with many infirmities, and among the most common is the subject of this paper. Sir Henry Thompson found, by an examination of two hundred dead bodies of men over 55 years of age, that about one in three exhibited some enlargement of the prostate; about one in seven manifested symptoms during life, which were severe in about half the cases; and he concludes that one out of every twelve to fifteen men approaching sixty years of age has symptoms sufficiently urgent to impel him to seek advice from the surgeon.

Is this a serious affection? Yes; I think it is. Let us glance at some of the results. The prostate is in intimate relation with the vesicoprostatic plexus of veins, and its enlargement produces congestion of the mucous membrane and walls of the bladder. On the other hand the enlargement by diminishing the calibre of the prostatic urethra causes obstruction to the flow of urine, and thereby the bladder is called on to produce greater efforts in expelling its contents, and hypertrophy ensues as a consequence. A residuum is left after urination, and, in the course of time, the mucus from the congested membrane acting on it sets up decomposition of urea and liberates carbonate of ammonia. This produces more mucus which acts as a ferment, and cystitis follows. Sacculi may be developed between the meshes of the muscular fibres on the walls of the bladder, and the formation of stone is not uncommon. The evil effects extend to the ureters and pelves of the kidneys, which become dilated and congested, and finally the substance of the kidneys may become congested and symptoms of uræmia may ensue. The patient's troubles are aggravated by loss of sleep, and the general inconvenience caused by frequent and painful micturition, and the catheterism which is so generally necessary.

Two deaths from hypertrophy of the prostate came under my notice last year. One

case was that of an old man who went into the General Hospital for retention of urine from enlargement of the prostate. On his admission the physician who had charge of the patient succeeded after some trouble in passing the catheter, affording great relief at the time; but bad symptoms, including those of uræmia, arose, and, in spite of all remedies, he gradually sank, and died in about four days. In the other case, which occurred in private practice under a well-known physician of this city, the history was nearly the same.

Without doubt, then, this is, in some cases, a very serious affection. But fortunately in the majority of those affected, the results are not so alarming. Let us suppose a case. An old man, at the age of 55 or older, comes to you complaining of frequent micturition, especially at night. He cannot force out his urine in the old-fashioned way, but is compelled to strain. The stream is slow in starting, and "dribbling" in nature. He has the various signs of irritability of the bladder. He feels generally "out of sorts" and in low spirits. You will probably suspect hypertrophy of the prostate, and place him on his back and examine with your finger in the rectum. It has sometimes appeared to me that some surgeons have a great objection to introducing the finger into the rectum. There is no occasion for such an objection; because, under ordinary circumstances, your finger won't do the rectum any harm. Of course, I take it for granted that no surgeon is afraid of his finger; for, if so, he had better give up the profession, and engage in something more suitable for his delicate digital extremities. The examination per rectum will generally give a fair idea of the shape of the gland, as well as the size, although you cannot judge with any certainty the extent of the obstruction to the flow of urine from what you feel in the rectum. You may find considerable enlargement while the flow is comparatively free, while on the other hand only slight enlargement may be detected; and yet the middle lobe, or, more correctly speaking, the posterior median portion alone may be increased in size so as to more or less completely block the entrance to the urethra, and thus impede or stop the flow. Having completed

your examination, you have confirmed your diagnosis, and after requesting your patient to urinate, you proceed to pass a catheter; and you will probably cause him great surprise after he has, as he supposed, completely emptied his bladder by drawing off from four to twelve ounces, or more, of urine. You cannot always be sure of the amount of residuum from one passage of the catheter, but you have now got all the information you can from one examination. Well! what is to be done? Will you send the old man home with a prescription, and strict injunctions to be very careful in his mode of living; to avoid violent exercise such as sculling, cricketing, and steeple-chasing; to abstain from sitting too long on an iceberg in the hot weather; to refrain from brandy and water at night, and cocktails in the morning; in fact, to avoid all excesses? Probably he has received a large portion of this valuable advice from his grandmother, and other kind friends at various times from his youth till now; and you had better, for your own sake, as well as his, do something more.

The consideration of treatment is a very important one. The symptoms will vary in different cases, principally in their degrees of severity, and of course complete retention of urine very commonly occurs, and is very frequently the occasion of our first consultation with the patient. Various medicines, such as iocine, mercury, hemlock, liq. potassæ, &c., have been tried; but I think it is now generally admitted that these remedies have no effect whatever in reducing the size of the gland when enlarged from simple hypertrophy. This admission is not universal, however, as some surgeons still claim good results from the administration of internal remedies. Dr. Washington L. Atlee read a paper before the Philadelphia County Medical Society in January of last year, in which he spoke very favourably of the good effects of fl. ext. of ergot in twenty-drop doses every four hours, and stated that in some cases patients were so much benefitted by this treatment that they were able to give up the use of the catheter, which they had been compelled to use for some time previously. I must say that I have but little faith in its efficacy, but in some cases it may

be worth a trial. Let us go back to our patient, whose ailments are all caused by an obstruction to the flow of urine, which is of such a nature that he is never able to empty his bladder. The evil effects are most serious in a man who has passed through his years of greatest vigour, and he, fully realizing the fact, is made exceeding wretched by these unpleasant evidences of senile decay. As a general rule his first request is for some medicine to relieve his distressing symptoms. If he receives the harsh, blunt answer, that no medicine can help him, but he will have to depend upon the use of an instrument for the rest of his days, he is very apt to receive the reply with the same kindly feelings that fill the breast of the criminal when receiving his sentence of death. Such patients are apt to be very sensitive, and you should exercise towards them the same kind consideration and delicate tact that you display in your treatment of the wayward child or the weak, suffering, hysterical woman. You should, if possible, gain their confidence, and explain, as well as you can, the nature of their affection, and the probability of rendering their lives comparatively comfortable by proper management. A gentleman of this city consulted Sir Henry Thompson last year for symptoms like those described in our patient. Sir Henry, on examining him, found enlarged prostate, with a residuum of about eight ounces, and, when telling him this, illustrated his condition by saying, "that if you took a barrel of water and put a tap in it six or eight inches from the bottom, the contents of the barrel would flow out through the tap down to its level, but not below; and added, that in the case of the bladder, the residuum below the tap would decompose and set up irritation." As a remedy, he directed him to use a catheter at least once a day, and twice or more if necessary. This gentleman was immediately convinced and charmed with Sir Henry's homely illustration. He at once cheerfully learned to pass his catheter, which he now uses daily, and as a result lives in comparative comfort. As our supposed case had symptoms, to a great extent, similar to the last, we will dismiss him with the same advice.

I may say, without discussing the reasons,

that nearly all are agreed that the catheter is the essential remedy for these cases. Dr. Van Buren, of New York, insists strongly upon this, and says that "the catheter is the natural specific for enlarged prostate just as the steel sound is for stricture of the urethra," and he also advises daily washing out of the bladder in all cases where the mucous membrane is continuously congested. But an important question arises—When should we commence? My answer is, at once. Van Buren says we should most assuredly do so whether there be any residuum or not. Thompson is not so positive, but would consider the amount of residual urine and frequency of micturition, but in most cases commences at once. Some think it is not necessary for a man with enlarged prostate to use a catheter, as long as his urine is clear, and he is suffering no great inconvenience. Sir Henry Thompson in reply says, that this means that a man is not to practise catheterism until after the occurrence of cystitis. But this is what we are most anxious to avoid; in fact we wish to avoid, as far as possible, all the bad effects, and our strongest hope lies in habitual catheterism. How often should the catheter be used? This must depend on circumstances. Sometimes it is only necessary to pass the instrument once a day before going to bed, the result being that the patient gets an undisturbed and refreshing sleep, and experiences no inconvenience the following day. In other cases it may be required twice or three times a day, and unfortunately in some cases it must be used very frequently. Each case must be decided on its own merits. As a general thing it is not a difficult matter to teach a man to pass a catheter, and there is commonly very little or no irritation produced by a soft flexible instrument. When there is a large amount of residual urine, say from half a pint upwards, it is better to use the catheter at certain regular intervals, and depend on it entirely, never attempting to void the urine without it. In the year 1875 I had a patient 74 years of age under my care for nearly a year, who had an enlarged prostate, although I was treating him for a different affection. He had commenced regular catheterism about four years

before, since which time he had passed a common gum elastic catheter three times a day. He passed it with the utmost ease, and suffered almost no inconvenience from it, certainly less than most of men at his age, even though, to use a common expression among them, their "waterworks may be in very good order." So slight was the inconvenience to him that he was able to use the instrument through a lingering illness of several weeks, which ended in his death, and I was only called on to do this duty for him twice, on the last day of his life. Within a stone's throw of this man was a friend of his of about the same age who had the same affection; and although I often tried to teach him to perform catheterism on himself, yet such was the difficulty in passing the instrument, and so feeble was the old man that it was impossible for him to accomplish it. While the other man suffered little or none from this cause, this patient suffered more or less all the time, and at irregular intervals of from one to three months I was called upon to treat him for retention of urine, which was generally accompanied with alarming constitutional symptoms lasting from three days to a week. In this case I found the irritability of the bladder and urethra most relieved by small doses of opium (gr. $\frac{1}{2}$) and, the old-fashioned incompatible combination of liq. potassæ and hyoscyamus. The contrast between these two cases, under observation at the same time, impressed me very strongly with the great advantages to be derived by the patient from the use of the catheter. In the same connection I may mention another case of a very healthy man about 68 years of age, who called me in to treat him for his first attack of retention of urine, caused by enlarged prostate. He was relieved very easily, and in a short time felt quite well; and although something was said about his learning to pass a catheter, still it was not done. He was not a regular patient of mine, and I lost sight of him for about a year and a-half, when I found him suffering severely from cystitis, with serious general disturbance to the system. I could not help thinking, in his case, that his sufferings were caused by the carelessness or neglect of his medical advisers (myself included) in not teach-

ing him to practise regular catheterism upon himself, and I now confess my share of the responsibility for such unfortunate results, privately to my fathers and brethren of this Society, with a great deal of shame. Although you will probably all agree in what I said before about this being a serious affection, still it is gratifying to witness the amount of relief which can be given in many cases by comparatively simple means. Even under the most favourable circumstances, however, some surgeons take a very gloomy view of the subject. In a discussion which took place in the Royal Medical and Chirurgical Society of London, in June of this year, Mr. Teevan stated that "a man who was compelled to use a catheter was as surely condemned to die as if he had cancer; it was only a question of time." Sir Henry Thompson, in reply, took a more cheerful view, and "protested against causing men who use the catheter to believe that life was thereby shortened. He knew a gentleman, who died at the age of 90, after using a catheter 22 years; and another gentleman at Norwich told him that he had used a catheter thirty-five thousand times. In the researches which he some years ago made in conjunction with Dr. Messent, on the old men in Greenwich Hospital, they found the average age at death to be 73; while that of those who used the catheter was $72\frac{3}{4}$." In these cases the most favourable condition is that of atony with probable dilatation; but in a certain proportion of cases, fortunately a rather small proportion, there is contraction with hypertrophy and irritability. Patients under such circumstances, after passing the catheter, only experience relief for a short time, and are compelled to use the instrument at short intervals of one to two hours, day and night. Their discomfort and pain may pass into an almost intolerable agony, which even opiates cannot relieve, and the tendency is to increase their sufferings until death comes to their relief. Sir Henry Thompson proposes to relieve them by making an opening into the bladder above or behind the pubes and placing a tube in it through which they may pass all their urine. He has done this in five cases with the result (to use his own words) "of rendering the short

remains of a closing life tolerable." For a description of the operation I must refer to his works.

I will close this paper with some remarks upon passing a catheter, including some of the hints I have heard Sir Henry Thompson give in his clinical lectures, delivered at University College Hospital. We should, of course, not forget the cautions given in all our text books about the danger in some cases of drawing off all the urine at one time when there is a very large amount in the bladder. This has been known to cause death and quite commonly produces cystitis.

I suppose, Mr. President, that every member of this Society who has a penis has passed a catheter on himself. If not, he should have done so. I have no idea that I will ever forget my first attempt when I was a student. I had purchased what I thought to be a very pretty silver catheter with, as I afterwards discovered, a most vile curve. I commenced the operation with considerable enthusiasm; but my ardour was damped in a very short time. The thing didn't fit, and wouldn't go, and in fact never did go. That, sir, was one of the most signal failures of my professional career. I may say that I have never since attempted to pass that instrument on myself or anybody else. I think, however, it taught me a useful lesson, and I will never again try to adapt the canal to the peculiar shape of my catheter, but will rather get the catheter to suit the shape of the urethra. No man will love you if he has any idea that you are giving him unnecessary pain in passing an instrument; and, apart from the pain, I think that every man has a considerable respect for that portion of his body, and likes to have it handled in a respectful and respectable manner. Well, in the first place, as to the best position for catheterism: I prefer to have the patient standing with his back to the wall if he is able to do so. I then sit on an ordinary chair in front of him. Teevan advises this mode of operating in all cases where possible. The advantages are that the surgeon has more power over his instrument, and therefore greater delicacy of touch. The passage is directly in front of him, and he can more

easily detect any deviations from the proper course, and he is less apt to make false passages, or cause any other injury to the sensitive urethra. In a patient, I have spoken of before, who often had retention, I had great difficulty in passing the instrument, and was sometimes able to accomplish it in this position after I had failed in any attempt while he was lying down. Erichsen, however, objects to the erect position, and says, "I certainly think that the recumbent is not only the easiest position in which to introduce the instrument, but the safest. In old and feeble subjects the sudden withdrawal of the urine, by removing compression from the abdominal veins, and allowing these vessels to refill, may induce syncope, which, occurring in the erect position might prove fatal." This danger, however, might be obviated by allowing the patient to lie down after the instrument has entered the bladder, or by drawing off only a portion of the urine at once.

In choosing an instrument, a soft rubber catheter causes the least pain, but I have found it of little use when there is obstruction. In a case of retention from enlarged prostate I commence with an ordinary English gum catheter about number eight, without the stylet, bent into an exaggerated curve extending to the point. Sometimes it is better to add a curve to the shaft in the opposite direction, which has a tendency to increase the curve at the distal end during its progress along the urethra, and thus make it pass over the obstruction into the bladder. It may be held for a moment in hot water, and then dipped immediately into cold water, which causes it to retain its curve for a longer time. The shaft of the catheter should be held closely back in the groin, and the penis gently drawn round the curve, which is required for the posterior part of the canal; and when it has passed well into the canal the shaft should be depressed. Another method is to introduce the catheter with the stylet, and when it has reached the middle lobe, slightly withdraw the stylet. This causes the point to move forwards and thus pass over the obstruction. If I have failed with the gum catheter without the stylet, I next prefer the silver prostatic catheter

with the long curve extending, as in the other instance, to the point, about 10 or 12 in size. Some surgeons, and among them Mr. Erichsen, think the metallic catheter is preferable to the gum because it is safer and more easily managed; while on the other hand the gum catheter is very unmanageable when the stylet is withdrawn, and if the stylet is left in it is as rigid and hard as the silver instrument. I agree with Erichsen in preferring the metallic to the gum catheter armed with the stylet; still, I have a firm conviction that the best instrument to commence with is the gum catheter without the stylet according to Thompson's directions. If all attempts at catheterism fail the urine may be withdrawn by the aspirator, introducing the needle above the pubes; and this may be repeated twice daily until you are able to pass the catheter. This is better than puncture per rectum or forcible catheterism.

Fortunately, however, with patience and care the surgeon is generally able by the above methods to enter the bladder, and the man is at once removed from his condition of extreme agony to the realms of bliss; and you have the proud satisfaction of relieving suffering humanity and earning the overflowing gratitude of your patient.

A FATAL CASE OF PURPURA HÆMORRHAGICA.

BY J. E. GRAHAM, M.D., TORONTO.

R. W., æt. 27, first called to see me in the latter part of March, when these notes were made. He has never been strong. Had anchylosis of the elbow joint, the result of old inflammation, which was operated on by Dr. Bauer, twelve years ago. Five years ago he had some consolidation of the right lung; for which he went south, remained in Florida during the winter, and returned much improved. About a year ago he had several patches of alopecia areata—the spots have since become covered over. He has been in moderately good health until about two months ago, when he noticed a numbness of the hands, and the appearance of small nodules on the fingers and on the backs of the hands. He also noticed some general swelling of the feet

and hands. The nodules are quite numerous, about the size of peas, and appear to arise from deposit in the deep fibrous structure. There are also smaller and more superficial ones on the forearm, which have been irritable, and have been scratched. They are numerous, and have somewhat the appearance of lichen.

I ordered for him alterative tonics, and as he was not able to take ol. morrhuae, gave ext. malt.

April 4th. The nodules have become larger, and some new ones have appeared. One quite large one has appeared on the side of the nose. The nodules have the same colour as the surrounding skin. The same eruption still exists on the forearm and legs. Found, on examination of the chest, no signs of recent disease in the lungs.

May 3rd. On my return to the city, after a week's absence, was told by Dr. Temple to-day that Mr. W. was very seriously ill, that he had pleurisy, as well as some trouble in the apex of the left lung. I called to see him on that evening. His mother told me that he had been very ill, but had improved considerably during the last two or three days. About a week ago he had exposed himself while in the country, and was seized with pain in the left side, which was accompanied with a good deal of fever. He was brought into the city, and under treatment had improved somewhat. On examination of the chest I found a friction sound on the left side of chest, close to the pericardium. Found also mucous rales at the left apex behind. He has been greatly troubled with nose bleeding. Appetite good, pulse 80. The nodules on the fingers have disappeared, as also the eruption on the arms and legs. Temperature slightly raised. He had been taking tr. ferri mur. and quinine. Ordered spirits turpentine in addition.

May 7th. He is very much troubled with nose bleeding. Had to apply a sponge soaked in sol. of tr. ferri mur. to stop it. His appetite is still good. Pulse 80, temperature 100.

May 9th. His nose has ceased bleeding. Noticed to-day, for the first time, a brownish discolouration of the urine. It contains blood in considerable quantities. Stopped turpen-

tine, and ordered gallic acid. He is also continuing the iron and quinine. Pulse 84, temperature 99.5.

May 12th. The hæmaturia still continues, and the blood is increasing in quantity. It was concluded to try again the styptic properties of turpentine. It was given in half-drachm doses. Pulse 96, temperature 101.

May 16th. Notwithstanding all the remedies used, the bleeding from the kidneys still goes on. The urine now passed is quite thick with coagulated blood. Noticed to-night for the first time that there was tenderness over the bladder. It was evidently much distended by coagulated blood. A consultation was held, and it was decided not to disturb the clot. Gallic acid with aromat. sulph. acid was ordered. He suffers a great deal of pain on passing water.

May 17th. Patient is easier this morning. He has passed a number of clots through the night. His countenance is blanched, and he feels very weak from the loss of blood.

May 18th. Patient is very weak, not able to move in bed, and can scarcely speak above a whisper. The coagula are again forming in the bladder, giving rise to great pain on micturation. Yesterday he was troubled with sickness of the stomach for the first time. Up to that time his appetite and digestion had been good. Ordered fl. ext. witch hazel.

May 20th. The urine passed last evening and to-day does not contain as much blood. The patient is better and stronger. The stomach is less irritable.

May 21st. Last evening he became worse. The blood is again increased in quantity. His stomach is more irritable, and the bladder is very much distended with clots. He suffers a great deal of pain in passing water, so much so that opium has to be administered constantly by the rectum.

May 22nd. Through the night the distension of the bladder caused a good deal of pain. He passed a small quantity of water this morning. The passage of urine is evidently impeded by pressure of clots. We noticed to-day a large swelling in the groin, caused by a large subperitoneal effusion.

May 23rd. No water passed to-day. He

has been delirious through the night, and is at times semi-comatose. Died at 4 p.m.

Post mortem examination made eighteen hours after death. Body somewhat emaciated. Purpuric spots found over the chest and thighs, the spots being from size of a pins head to that of a pea. On opening the abdomen a quantity of fluid escaped. Small patches of extravasation found on the intestines in every part. These spots appear to be caused by small effusion of blood immediately beneath the peritoneum. Bladder distended with coagula. It extends about half way up to the umbilicus. On removing it, found it distended to its greatest extent. As soon as an opening was made in its walls the fluid and blood clots escaped with a gush. The organ filled up the whole cavity of the pelvis, so much so that it was almost impossible to get the hand around it. It was remarkable that although the bladder was distended to such an extent it did not rise higher above the pubes than two or three inches. In fact, before death, we were not aware that so great an amount of distension existed.

Kidneys. Substance pale. The left one was enlarged, and appeared to be partly filled with fluid. The pelvis, and the inner surface of ureters showed the presence of coagula beneath the epithelial surface. The hæmorrhage appeared to come from the pelvis, and not from the substance of the kidney.

Liver. Slightly enlarged, and pale. Spleen enlarged, and apparently congested.

Beneath the parietal portion of the peritoneum, especially at its lower part, there are extensive extravasations of blood. There were also extensive extravasations beneath the mucous membrane of the bladder. On the left side of the thorax there was a patch showing the presence of inflammatory deposit. This was in the situation of the friction sound during life. The patch was quite elongated, partly made up of inflammatory exudation, and partly of extravasated blood. At the apex of both lungs deposits were found of a hard cretaceous nature. At the left apex there had apparently been active trouble.

The heart was found healthy.

Brain not examined.

Points to be noticed in this case are as follows:—

(1) Appearance of nodules previous to the onset of the disease. At least three months before the final attack these nodules were noticed. They existed in the deeper cellular structure, and were most probably produced by a slight effusion of blood. The numbness of the fingers may have been produced by pressure of the nodules on veins.

(2) Presence of more or less fever during the attack. The fever was noticed to be rather remittent in character. It was no doubt partly produced by local inflammation, the result of the presence of extravasated blood.

(3) The absolute uselessness of all known remedies for the disease. There was no apparent benefit resulting from any medicine used. The hæmorrhage from the kidneys appeared somewhat arrested after the administration of the fl. ext. of hamamelis, and in the treatment of another similar case I would try the remedy earlier in the disease. The remedies used were turpentine, ergotin injected hypodermically, gallic acid, aromat sulph. acid, tr. ferri mur., and fl. ext. hamamelis.

(4) Our knowledge of the pathology of this disease is in quite as unsatisfactory a state as is the treatment. Does the diseased condition exist primarily in the blood or in the blood-vessels? The theory of some German authorities is, that the diseased condition exists in a contraction, and reduction in calibre of the blood vessels, and the passage out of the blood from the vessels on account of their being surcharged with blood, would seem to be, to a certain extent, substantiated in this case by the character of the pulse. The pulse not becoming weak from continuous loss of blood, as one might expect, but retained its fulness and tension almost to the last day. On the other hand, in this case the blood seemed to retain its power of coagulating. The coagula which formed in the bladder were very firm indeed; and the blood did not differ in colour from ordinary venous blood. Other theories have been given. Buhl ascribes it to debility of the heart's action, and defective nutrition of the blood-vessels; Moneret, to a deficient formation of fibrine; and another ascribes it to an over distended condition of the blood-vessels in consequence of deficient secretion of bile.

French suggests that there is an abnormal relation between the walls of the vessel and the blood which has become altered in composition, from which arise obstruction and rupture of capillaries.

(5) The formation of firm coagula in the bladder was a circumstance which led to a good deal of difference of opinion as to treatment. Some of the physicians in consultation were in favour of leaving the coagula alone, and others were in favour of breaking up and removing them with a large-sized catheter. It was however decided not to interfere, and, on reviewing the case, I cannot but think that it was the better plan, as any interference would, no doubt, have increased the hæmorrhage. On this point I found a similar difference of opinion among the authorities. Erichsen, among others, is in favour of removing the coagulum; and Sir Henry Thomson and Van Buren say that under such circumstances the bladder should be in no way interfered with.

In this case the hæmorrhage seemed to arise from vessels in the subserous and submucous tissue. This is the usual seat of extravasation.

7 A peculiarity was the determination of blood to the kidneys and to the pelvic viscera. It will be remembered that the hæmaturia began after the administration of turpentine, whether the administration of this drug had anything to do with such determination or not is a difficult question to decide.

My object in reporting this case is not to throw any new light on this obscure disease—because this, for me, is impossible—but to elicit the opinion of others, who, in their long experience, may have made some observations on this very puzzling diseased condition.

I must confess that I have seldom treated a case in which I felt so great a lack of knowledge, both as to the pathology and therapeutics.

ANOREXIA—MIXTURE FOR APEPSY.

℞ Tincture of nux vomica gtt. v.
 Extract of gentian grs. xv.
 Syrup of bitter orange peel. ʒiiss.
 Quinine wine ʒivss.

Make a solution.

One half to be taken half an hour before each of the two principal meals.—*Le Prog. Med.*

Translations.

ON THE BLOOD CIRCULATION OF THE CORPUS STRIATUM.

M. Hallopeau has made a number of examinations of the brain, in which he has been able to establish that the sylvian artery is not the only one that furnishes vessels to the corpus striatum, but that it also receives anterior cerebral and anterior choroidal branches.—*Gazette des Hôpitaux.*

TREATMENT OF GRAVE TUBERCULAR LUPUS OF THE FACE.—HARDY.

1. Cover the parts invaded by the tubercles with an ointment made as follows: Bromide of mercury 6 grammes, axungia 20 grammes.

2. Cod liver oil, two table-spoonsful night and morning.

3. Take morning and evening, before meals, a table-spoonful of the following solution: Distilled water 300 grammes, chloride of sodium 15 grammes, iodide of potassium 5 grammes. (Very considerable amelioration in two months.)—*Le Progrès Médical.*

DIAGNOSIS BETWEEN ACUTE MILIARY TUBERCULOSIS AND PARENCHYMATOUS NEPHRITIS.

Touching a note on a case of acute miliary tuberculosis, affecting most of the organs and particularly the vaginal mucous membrane, M. Quinquaud states,—The observation of M. Rigal is very interesting from many points of view. I will consider only one of them, the difficulty of the diagnosis. According to the symptoms and evolution of the disease, M. Rigal had very reasonably made the diagnosis of scarlatinous nephritis and uræmia. The autopsy demonstrated that death had been produced by acute miliary tuberculosis.

The chemical examination of the blood might have thrown some light on the case. In truth, in parenchymatous nephritis, the hæmaglobin is lowered 62 grm. per 1,000: in the interstitial form it remains at 72 grms., more often at 75 grms. Again, in parenchymatous nephritis the solid matters of the serum descend below 62 grms., whilst in interstitial nephritis they remain at 75 grms. or over.

Let us oppose these alterations to those of acute miliary tuberculosis. The hæmoglobin reaches 90 grms. or remains above; the solid matters of the serum are at 92, 94, 90 grms. It is then possible to establish, by the help of these data, a differential diagnosis.

Finally, if there had been a co-existence of acute miliary tuberculosis and parenchymatous nephritis, the chemical examination of the blood and the thermometer might help the diagnosis; in these cases we find the chemical alterations of parenchymatous nephritis with increase of temperature, which can be explained neither by the existence of the nephritis nor by the uræmic accidents.

To estimate the hæmoglobin I employ a method essentially chemical, of great exactitude: we make use of a solution of hydro-sulphite of soda, which measures the oxygen of the blood with an approximation of 0^{cc}.01 per 100; now in saturating the liquid blood with oxygen we can establish its value in hæmoglobin, since 240 cu. centig. of oxygen correspond to 125 grms. of oxydizable matter; it is a simple sum in proportion. In this manner we appreciate the quantity of crystallizable substance with a maximum error of 5 centig. per 100 grms. of blood.—*L'Union Med.*

AUTOPSY OF PURULENT PLEURISY—IMPOSSIBILITY OF RECOVERY—GOSSELIN.

Yesterday we had occasion to make an autopsy upon a patient who succumbed to a purulent pleurisy, for which we had before practised the operation for empyema. I wish to profit by this example, to draw from it a precious lesson. This autopsy has demonstrated, once more, that recovery may be obtained after the operation for empyema, only if the lung can still dilate itself. You have seen, in fact, that the lung was altogether flattened against the vertebral column, that it was not dilated and could no longer be dilated, in such a manner that there existed, between the lung and the costal wall, a vast cavity in full suppuration. In order that recovery may be obtained after the evacuation of the chest by the large opening of the purulent centre, the lung must still be in a condition to fill this pleural cavity by dilating itself and by coming

to adhere to the thoracic wall, consequently causing the primitive cavity to disappear. If the lung do not form adhesions to the parietal leaflet of the pleura, the cavity will persist, there will remain a great purulent cavity of the pleura which will continue to suppurate without end. Recovery becomes absolutely impossible. It is true they say, that in children recovery may take place with preservation of the pleural cavity. I am scarcely disposed to accept this opinion. In any case, in adults this never happens so. Definite recovery takes place only if the lung recovers a certain elasticity and a sufficient permeability, if not, the operation for empyema will only cause the death from septicæmia to be retarded.

So I cannot repeat to you too often that it is not necessary to be in a hurry to perform thoracentesis in simply serous pleurisy; it is a seductive operation, but it gives magnificent results only in cases in which the subjects are not tuberculous and in which the effusion is not reproduced. If there is the least disposition to suppuration, it is necessary to be guarded in punctious of the pleura, far better wait until it has suppurated spontaneously, unless, be it understood, the effusion by its extent threatens the life of the patient by asphyxia or syncope.

Our patient had been thus tapped for a serous effusion, which was reproduced many times afterwards, and which after a third tapping became purulent. In fine, let us note that at the autopsy we found tubercles in the lungs, as well as in the meninges; at the level of the tuber cinereum and the optic thalamus there existed even a point of suppuration.—*Gaz. des Hôpitaux.*

DISEASE AND ITS HÆMATIC INDEX.

M. Petit read a work of M. Quinquaud on disease and its hæmatic lesion.

According to this author, each morbid species in nosology carries in its train a corresponding peculiar alteration of the blood. Here are some examples:

(a) In simple dilatation of the stomach, the hæmoglobin remains above 90 grms. (normal figure 125 grms. per 1000) the absorbing power of the oxygen at 174 cu. centig. (normal figure 240 cu. centig.).

(b) On the contrary, in cancer of the stomach, the hæmoglobin descends to 52 grms., and the absorbing power to 100 cu. cent.

Nevertheless, in cancers in general, we find a great destruction of the hæmoglobin, which may descend during the stage of full development to 28 grms., whilst the solid materials of the serum are slightly separated from the normal.

(c) Hæmoglobin, in interstitial nephritis, reaches the figure of 72 grms., its absorbing power to 140 cu. cent., the solid materials remain at about 74 grms.

(d) It is otherwise in parenchymatous nephritis when the hæmoglobin is lowered to 65 grms., the absorbing power to 126 c. cg., the solid materials of the serum to 64 grms.

(e) In *scurvy* the hæmoglobin attains the figure of 57 grms., the absorbing power 110 cu. centig.

(f) In *purpura simplex*, the hæmoglobin descends towards 70 grms., the absorbing power to 134 cu. centig., whilst in *purpura hæmorrhagica*, a little severe, the crystallizable substance of the blood is at 56 grms. and the absorbing power at 108 cu. centig.

(g) In true chlorosis, the hæmoglobin is destroyed in large proportions, arrives at 50 grms., the absorbing power remains at 96 cu. centig., but the serum remains perfectly healthy. This is almost the only affection which is characterised by such a lesion.

(h) Thoracentesis produces some modifications on the blood crisis; the hæmoglobin is lowered only in the few days which follow the operation. and soon this substance attains its primitive rate, the absorbing power diminishes equally. It is absolutely the same with the solid substances of the serum.

If the disease tends to suppuration, the curve of these lesions becomes decreasing. This is a sign which is valuable in discovering the suppuration of the pleura.

(i) These chemical analyses of the blood permit again of showing that there exists a difference between true pneumonia and typhoid pneumonia. In the first the hæmoglobin does not arrive at 100 grms., whilst in the second it descends to 70 72 grms. In the first the solid substances of the serum remain at 88 grms., in the second they arrive at 72 grms.

(j) In the renal tubulhæmia of Prof. Parrot there is scarcely an absorbing power of 30 cu. centig.

(k) The blood of the pregnant woman is less rich in hæmoglobin than that of the fœtus: mother's blood 96 grms. of hæmoglobin, fœtus, 95 grms. The fœtus, above all, uses the solid materials of its serum.

It proceeds from these hæmatological studies that there is often great interest for the physician to make analyses of the blood. They serve to establish a diagnosis and prognosis on solid foundations.

DIPHTHERIA.

We append the conclusion of one the most interesting papers on diphtheria that we have met with. It is an account of 108 autopsies of diphtheritic patients dying in the wards of Dr. Triboulet at the *Hôpital Sainte-Eugénie*, between the months of August, 1877, and December, 1878, and was presented by M. Ch. Talamon to the *Société Anatomique*, on the 28th Feb., 1879. If we had entertained any doubts as to the identity of croup and diphtheria the perusal of this paper would have entirely removed them beyond a peradventure. We greatly regret that want of space prevents us from presenting the entire communication (which is very long) to our readers—

“ We shall sum up, in a few lines, in conclusion, the principal facts which appear to us to result from these statistics. Diphtheria, a systemic affection, determines in the organism two sets of alterations: lesion of the surface, and deep or visceral lesions. The former affect the mucous membranes in contact with the atmospheric air; these are the pseudo-membranous inflammations, which are characteristic of diphtheria, in the same way as the lesions of Peyer's patches are characteristic of typhoid fever, or the variolous eruption of smallpox. The deep or visceral lesions are analogous to these of all the infectious diseases. They are generalized throughout the economy, but predominate or are more especially manifest in certain organs. We have observed them almost constantly in the lungs, the intestine, the liver, the kidneys, and the lymphatic organs. The generalization would doubtless

have proved to be more complete if microscopic examination of all parts, the muscles, glands, nervous system, etc., had been made. It is, in fact, very probable that if alterations in these organs escape detection by the naked eye, this is because they are, so to speak, only in the nascent state, and because the disease kills too quickly to afford them time to go through their evolution and become as apparent as in the infectious diseases of long duration such as typhoid fever.

The pulmonary and intestinal lesions have been, in our observations, the most common and most manifest. The respiratory and digestive apparatuses are, in fact, the two whose functions present most activity in the child. In the lungs, pseudo-membranous or purulent bronchitis with lobular, or pseudo-lobar, splenization. In the intestine, soft, white or red tumefaction of Peyer's patches, and prominence of the isolated follicles, constitute the alterations whose occurrence may be regarded as the rule. The intestinal lesions are located in the ileum, and present their maximum in the lower half, towards the valvule of Bauhin, as in typhoid fever. They are accompanied by swelling and violent congestion of the mesenteric glands. It may be said that inflammation of Peyer's patches and psorentery with mesenteric adenitis, are as frequent in diphtheria as is broncho-pneumonia with bronchial adenitis. The pseudo-membranous and visceral localizations of diphtheria, although governed in a general way by the gravity of the diphtheritic infection, appear to obey, in a certain measure, the influence of the seasonal constitution. As the result of our autopsies we believe that we are justified in the conclusion that during the six winter months diphtheria expends its force more especially upon the respiratory passages, and during the six summer months upon the digestive tube: that, in other terms, the diphtheria of winter is rather laryngo-pulmonary, and the diphtheria of summer pharyngo-intestinal.—*Le Progrès Médical.*

COTTRELL & BABCOCK, No. 8 Spruce Street, New York. We have received a beautiful chromo, "The Village Belle," from the above firm. It was printed on their *Four-roller Cylinder Press*, and is elegantly done. Illustrated catalogues of their presses will be sent on application to the above address.

THE CANADIAN
Journal of Medical Science,

A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by sending reports of the proceedings of their Associations to the corresponding editor.*

TORONTO, NOVEMBER, 1879.

ATTENTION!—A man was recently convicted of a petty theft before a police court. He had once been a prominent physician, and dated his downward course from the time that he cheated the publisher of his medical journal out of the subscription price. After that, he said, he found that every piece of rascality came easy to him. The moral here need not be pointed out, and we shudder for the future of some.

WARNER'S SUGAR-COATED PILLS
AND PHARMACEUTICAL PRE-
PARATIONS.

The following excerpts are from the *Medical Press and Circular* and *British Medical Journal*, whose words of commendation we heartily endorse:—

It is of some importance that medicine should be administered in as small a compass, and in as palatable a form as possible. We therefore hail with pleasure any improvement that is made in this department of pharmacy. To some of these pills we have given a fair trial. They are elegantly prepared, the sugar coating being an especially grateful vehicle to fastidious patients, and we have found them to answer every purpose for which they are intended. We can moreover, recommend the phosphorus pills, provided they are taken only under medical supervision, * * * *

This firm has also prepared from the gizzard of the domestic fowl a new and excellent kind of pepsin, called *Ingluvin*. It is suitable for all those cases of gastric disorder for which pepsin is usually given, and owing to the well-

known idiosyncrasy of the stomach, will be found to succeed when other similar preparations have failed.—*Ed. Medical Press and Circular, London, April, 1879.*

We have also received from Messrs. Warner & Co. samples of their pharmaceutical preparations for the use of physicians and practitioners. These preparations have received high awards at the continental and other international exhibitions, and have attained a considerable reputation in America. Warner & Co.'s sugar-coated pills are extremely well made; have a smooth elastic coating; and, if cut through, the mass within is found to be soft and easily soluble. They include phosphorus pills, containing $\frac{1}{60}$ of a grain of phosphorus in each; have been especially praised by the judges on account of the completeness with which the phosphorus is diffused and subdivided, whilst it is preserved from oxidation. "Ingluvin" is a preparation of pepsin extracted from the ventriculus callosus of the fowl, and is said to possess considerable peptic power, and to be especially successful in the prevention of vomiting in pregnancy, as well as a powerful and reliable remedy for the cure of indigestion and dyspepsia generally. A very convenient pill is a sugar-coated pill containing two grains and a-half of extract of colocynth and a quarter of a grain of podophyllin corresponding to what are popularly known as "anti-bilious pills." Another set of their preparations, which they call "Parvules," consisting of alkaloids and active principles diffused in small sugar-coated granules, constitute, in our opinion, a distinct progress of pharmacy. There is no reason why a series of parvules or granules should not be prepared containing the legitimate dose of strychnia, belladonna, ergotine, morphia, and so on, which should be absolutely reliable in use, extremely portable, potent, uniform, and agreeable both to the eye and palate. A well-assorted selection of sugar parvules or granules impregnated with all the various alkaloids and active principles and their salts could then be carried in the coat-pocket or could lie on the study table, and enough medicine for an army could be contained in a moderate sized cabinet. We have no doubt that the time is approaching when a surgeon's dispensary need not, for all

practical purposes, occupy more than a corner of his study, and when ordinary dispensing will become a scientific manufacturing art, supplying ready to hand about three or four score active principles diffused in sugar granules, by the combination of which all the exigencies of the most refined and intelligent practice will be sufficiently met. Messrs. Elliot & Co, Toronto, are the agents for these preparations.—*Ed. British Medical Journal, April 12, 1879.*

Book Notices.

Laceration of the Cervix Uteri. By A. REEVES JACKSON, A.M., M.D. Read before the Chicago Medical Society, July 7th, 1879.

On the Connection of the Hepatic Functions with Uterine Hyperæmias, Fluxions, Congestions, and Inflammations; with Appendix. By L. F. WARNER, M.D., Boston.

Real-Encyclopädie der Gesammten Heilkunde. Medicinisch-Chirurgisches Handwörterbuch Für Praktische Ärzte-Herausgabe geben. Von Dr. Albert Eulenburg: ord. Professor an der Universität Greifswald. Wein, 1880.

The Multum in Parvo Reference and Dose Book, by C. HENRI LEONARD, M.A., M.D., Detroit, contains, besides Doses of all Preparations, official and non official, Remarks on Pharmaceutical Preparations, Rules for Pronunciation, Incompatibles, Rules for Genitive Case Endings, in Prescription Writing; Poisons and their Antidotes, Tests for Poisons and also for Urinary Deposits; Obstetric Department, Visceral Measurements, Abbreviations, Tables of Weights, &c., &c., all in a small book of 100 pages. The book is good of its kind, but as we have before had occasion to remark, such books encourage habits of laziness and carelessness, and contain a great deal that should be carried in the head and not in the pocket.

The National Dispensatory; Containing the Natural History, Chemistry, Pharmacy, Action, and Uses of Medicines, including those recognized by the Pharmacopœias of the United States, Great Britain, and Ger-

many, with numerous references to the French Codex. By ALFRED STILLE, M.D., LL.D., and JOHN M. MAISCH, Phar. D., second edition, thoroughly revised, with numerous additions. Philadelphia: Henry C. Lea, 1879; Toronto: Hart & Rawlinson.

That within the short space of six months a second edition of this work is called for, is perhaps a stronger testimony than anything we can urge as to the excellence of the book. We had the pleasure of reviewing and commending it in our May number, and have only to add to what we then said, that about one hundred pages of new matter have been inserted, and all new investigations have been noticed. Some illustrations have been added and a few changed. The Therapeutical Index has been extended by the addition of 2,250 new references.

The Summer, and Its Diseases. By JAMES C. WILSON, M.D. Philadelphia: Lindsay & Blakiston, 1879. Toronto: Hart & Rawlinson.

This is the fourth volume of the American Health Primer Series, edited by Dr. W. W. Keen, of Philadelphia, and is a very readable little book, intended rather for the general public than for the profession. Its seven chapters treat of "The Summer," "Sunstroke and Heat Fever," "Summer Diarrhœa and Dysentery," "Cholera Infantum," "Summer and Autumnal Fevers," "Summer Colds and Hay Asthma," and "The Skin in Summer, and its Diseases." We like the style in which the book is written; the author evidently fully understanding what sort of medical literature should be placed in the hands of the laity. Under Rules for the Management of "Infants during the Hot Season" no mention is made of the whey diet. This is, we think, an important omission; although, of course, the author does not pretend to give more than brief general directions as to the management, during the absence of a physician, of the above-mentioned maladies.

Student's Pocket Medical Lexicon. By ELIAS LONGLEY. Philadelphia: Lindsay and Blakiston. 1879. Toronto: Hart and Rawlinson. This little book merits no commendation.

It is neither complete nor correct. The author, who, by the way, is not a medical man, advocates the phonetic system of spelling, and the book is gotten up upon the basis of the American Phonetic Alphabet, to suit the literary attainments of those who have not been "favoured with a liberal education." The first reference we made to the book for a definition of a term proved fruitless, and the pages teem with absurdities. "*Cephalic*" is pronounced with the *c* soft. "*Ceratomyxis*" is defined as "puncturing the cornea in operating for catarrh." "*Cervical*" is pronounced with the accent on the first syllable. "*Clitoris*" is a small gland anterior to the vulva. "*Epithelium*," the thin cuticle that covers the lips, nipples, etc., that are destitute of the ordinary skin. "*Hypodermic*," application of medicines externally after the skin has been removed by blistering. "*Impetigo*," a humid running tetter. "*Jaundice*," a bilious disease attended with yellow skin and eyes. In "*Umbilical*" the accent is placed on the antipenultimate. "*Diastole*," the periodic action of the heart and arteries. "*Zymosis*," fermentation; applied to diseases resulting from miasmatic influences: and so on *ad nauseam*. We selected the above at random in turning over the pages.

A Guide to Surgical Diagnosis. By CHRISTOPHER HEATH. Philadelphia: Lindsay & Blakiston. Toronto: Hart & Rawlinson.

In this little work, surgical affections are grouped anatomically, *i.e.*, different parts of the body are taken separately, commencing with the head, and the symptoms of these affections or injuries peculiar to each region are described as clearly as the extreme brevity will allow. This arrangement is the same as that followed by the author, and other able clinical teachers, at the bedside, when the presence of the patient impresses the symptoms upon the mind of the student; and he is not apt to forget the lessons thus learned, if at the same time he faithfully studies one or more of the many valuable text-books now available.

While the general plan of the book is good, the matter is too meagre to be of much use to the young practising surgeon, or the advanced student; but we suppose it will be received

with delight by that too numerous class, who are always on the look-out for "tips," or "short cuts" into the good graces of their examiners. We would like to impress upon students, that there is no "royal road" to a knowledge of surgery, and consequently they should be content to acquire that knowledge and skill by industry and perseverance, spending as much of their time as possible in the hospitals, and using such text-books as Erichsen and Ashurst, or numerous others that we might mention. We think it should be the object of a distinguished surgeon, like Mr. Christopher Heath, to teach surgery, rather than help candidates to cram just enough information to enable them to squeeze through their examinations.

Physiology and Histology of the Cerebral Convulsions. Also Poisons of the Intellect. By CHAS. RICHET, A.M., M.D., Ph.D., Paris. Translated by Ed. P. Fowler, M.D. New York: Wm. Wood & Co. Toronto: Hart & Rawlinson.

This interesting and valuable little book, considerably abridged in its Anglo Saxon garb, is presented by its translator as a fit complement to his translation of Charcot's "Localization in Diseases of the Brain." Being a simple record of the facts pertaining to this subject, acquired to science in the past, and eschewing all doubtful and disputable matter, the work presents but a limited field for criticism, and all we have to say is commendatory. The translation has been well and faithfully done, and English readers are indebted to Dr. Fowler for a compendium of scraps of knowledge only to be found, so far as we are aware, scattered throughout the periodical literature and the transactions of the learned societies of England, France, Germany, Italy, and America. The work is divided into four sections: two Parts, and two Chapters. Part First treats of the Structure of the Convulsions; Part Second of their Physiology. Chapter First relates to their Physiological Properties; and Chapter Second to their Functions. The Appendant on "Poisons of the Intelligence" is also an abridgment of a monograph by the French author bearing this title, and is a short chapter presenting an analysis of the symptoms resulting

from the action of alcohol, chloroform, haschisch, and coffee on the brain. It is an interesting addition to the book, but presents nothing strikingly new or original. The work, as a whole, will prove indispensable to English readers desirous of being *au courant* with the times. No exception can be taken to the get up of the book, whose style and appearance reflects nothing but credit upon its publishers, Messrs. Wm. Wood & Co., of New York.

Analysis of the Urine. By K. B. HOFMANN, Professor in the University of Gratz; and R. ULTMANN, Docent in the University of Vienna. Translated by T. Barton Brune, A.M., M.D., of the Maryland University Hospital; and H. Holbrook Curtis, Ph. B. New York: D. Appleton & Co., Broadway Toronto: Hart & Rawlinson. 1879.

This valuable manual of urinary analysis is a work which has attained much deserved popularity amongst students of medicine and practitioners in the Vaterland; and we venture to bespeak for its translation an equally favourable reception in the New World. The subject matter of the book is preceded by a short introductory chapter giving an interesting but necessarily very brief account of the historical progress of urinary analysis from the days of Hippocrates until now. Chapter i., a short one, is devoted to a cursory glance at the histology of the urinary organs; and its still more brief successor deals with the excretion of the urine. After a rapid survey of the various theories upon the subject, the honest conclusion is arrived at, that "a perfectly satisfactory explanation of the secretion and excretion of the urine in all its details is wanting." Then follows an admirable chapter (iii.) on the urine, its physical, chemical, and microscopical properties and constituents in health and disease. This we cannot too highly commend to the careful perusal and leisurely digestion of the student; while we are persuaded that the busy practitioner, puzzling over some disappointing and unsatisfactory analysis, will herein find many a ray of light to clear up his perplexing difficulties. A brief chapter (iv.), describing reagents and apparatus, is here inserted; after which comes an excellent account (chapter v.) of the

quantitative determination of the principal constituents of the urine. Chapter vi., entitled "Key to the Approximate Analysis of the Urine," presents a ready help to the rapid analysis of a given specimen. Chapter vii. takes up general diagnosis: and here we have one omission to note, which is, the occasional occurrence of anuria as a symptom of hysteria. The specific diagnosis of diseases of the urinary apparatus is considered in the final chapter viii. The subject is here dealt with under three classifications:—

A. True Albuminuria, comprising 1. Hyperæmia of kidney, 2. Parenchymatous nephritis (in its various forms), 3. Interstitial nephritis, 4. Amyloid kidney.

B. Forms of Mixed Albuminuria, comprising 1. Pyelitis (four varieties), 2. Hæmatinria, 3. Cysto-pyelitis and pyelo-cystitis.

C. Forms of False Albuminuria, comprising 1. Cystitis, 2. New growths in bladder, 3. Bladder stone, and 4. Diseases of the urethra and prostate.

Throughout, the book is characterized by sound doctrine, scientific accuracy, and careful compilation; while, as a translation from a foreign tongue, its lucidity of style, terseness, and perspicuity are veritably surprising. It cannot fail, in our opinion, to attain the end set before its authors in its preparation, and prove a most valuable aid alike to student and practitioner in the urological diagnosis and study of disease. Eight very good double plates, portraying the microscopic deposits of the urine, complete the book.

Typographically, the text is all that could be desired, the print being beautifully clear and large; but we would venture to suggest to the publishers, Messrs. D. Appleton & Co., that a work intended for such frequent reference would be the better for being more strongly bound.

"Flint's Clinical Medicine," "Galabin on Diseases of Women," "Berkhardt on Asthma," and Vols. III. and V. of the "American Health, Primer Series," "Long Life and How to Reach it," and "Eyesight and How to Preserve it" will be noticed next month.

Meetings of Medical Societies.

TORONTO MEDICAL SOCIETY.

At a meeting held Oct. 9th, Dr. Oldright presented a patient, a boy, from whom he had removed a cyst situated on the frontal bone. The growth had produced some absorption of bone. Dr. Oldright also showed an encephaloid growth removed from the neck, being situated beneath the angle of the jaw. Dr. Alt reported a case of sympathetic neuro-retinitis. Patient with congenital cataract of both eyes. Some operation had been performed on the left eye, in England. On examination the cataract was found lodged in the anterior chamber of the left eye. There was cyclitis—no vision. Photophobia in right eye, but no sympathetic inflammation. The left eye was enucleated. This was followed by pain, slight inflammation and sluggishness of pupil of right eye and neuro retinitis which yielded to treatment. Dr. Zimmerman presented stomach and heart taken from a middle-aged man, found drowned. The coats of the stomach were greatly thickened and the pylorus narrowed, probably due to whiskey drinking. The heart showed a calcareous mass in the muscular substance of the posterior wall of left ventricle.

Dr. McPhedran then read a paper on Cystitis, giving the varieties, causes, pathological changes and treatment.

At a meeting held Oct. 23rd, Dr. Alt presented a tumour removed from the orbit of a gentleman. The growth extended from the outer to the inner angle, and appeared to be solid. Two years before, it had been operated upon and some cheesy matter squeezed out. A second operation was subsequently performed in New York, but the growth returned. The eyeball was pushed downwards and outwards. The growth appeared to start from the lachrymal gland, which was also removed. Microscopically it presented the appearance of an adenoma. Dr. Oldright related a case in which he had removed a sebaceous tumour from the cheek, and while doing so a second tumour appeared in the cavity, which had a pedicle attached to it, and passing through a small opening in the Buccinator muscle. This growth, which was about the size of a marble, was returned and

left. Dr. Macdonald related the history of a patient who had been in the habit of passing a catheter at intervals to dilate a stricture, and a few days before had broken off about an inch and a half of a conical No. 10 French catheter. After dilating the stricture, Dr. Grasett saw the patient in consultation, and was fortunate enough to seize the fragment in its long axis, with a Thompson's lithotrite, and extracted it. Dr. Alt read a paper on Tumours of the Anterior third of the eyeball other than epithelial, and illustrated his paper by microscopical preparations and drawings. He classified these tumours under two heads, benign and malignant. In the first class he placed Lymphangiomata, Telangiomata, Serous Cysts, Granulomata, Dermoid, Fibromata, Papillomata, Melanomata. Under the second class he placed Leuco and Melano, Sarcomata.

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PARTIAL LEUCODERMA (VITILIGO) OF THE INSANE (DOTT. EMICO MORSELLIS.)

1. There exists a form of leucoderma which, being developed in mad men, may be distinguished as the leucoderma of the insane.

2. This dermatosis is characterized by the disappearance of the cutaneous pigment over a more or less extensive area, the borders of which are sometimes deeply pigmented. Such unequal distribution of the colouring matter is, anatomically speaking, a true dystrophy of the *rete Malpighi*.

3. This confirms the existence of that affection of the skin which developed in consequence of strong moral emotions, or grave and sudden psychic disorders, or at the end of long and debilitating nervous affections was admitted into dermatology under the name of "emotional dermatosis."

4. The leucoderma of the insane has well defined characters, distinct from other cutaneous affections in form, seat and definite appearances.

5. It appears, preferentially, in certain madmen who present more or less marked symptoms of excitement of the psychic faculty.

6. Regarding its pathology, it will probably enter along with many other dermopathies of nervous origin into the category of vasomotor and trophic neuroses.—*Rivista Sperimentale di Freniatria e di Medicina Legale.*

Miscellaneous.

HOW TO GARGLE THE NASO-PHARYNX.—When the gargle is designed to reach the naso-pharynx, Dr. Löwenburg recommends the following method:—The patient inclines the head horizontally backward, and performs movements which we may call "quasi-deglutition," not including the last portion of this physiological action, definite swallowing. The liquid is passed much higher behind the soft palate than the ordinary method of gargling will permit; some persons succeed so well in this manœuvre that they are able to reject by the nose the liquid which has been received by the mouth. Moreover, these rapid muscular contractions completely detach the abnormal secretions, which can then be easily expelled, and the greatest possible relief is thus given to the patient.

A PECULIAR MICROCOCCUS IN GONORRHEAL DISCHARGE.—In the *Centralblatt für Med. Wis.*, July 12th, Dr. Albert Neisser, of Breslau, announces the discovery of a peculiar form of micrococcus in gonorrhæal pus. It is circular, or oval in outline, not coloured by indulin or methylgreen, usually in colonies of ten, twenty or more, surrounded by a membrane, generally found on the upper surface of the pus cells, rarely on the epithelial cells. Dr. Neisser found these bodies in the gonorrhæal discharges of both sexes, in acute and chronic cases, and in various cases involving the eyes. He believes they are characteristic of the disease, though he does not express himself positively on their pathological significance.

CROSS'S SUSPENSORY BANDAGE.—MR. J. B. Cross, a student at Guy's Hospital, has devised a very simple, and at the same time cheap and serviceable, Suspensory Bandage. It consists of a bandage round the waist, to the middle of the back of which is tied a strip of flannel four inches wide, which is brought round the perineum to the front and fastened to the band; in this is a slit for the penis. Just behind the penis the middle of a another strip of flannel is fastened across the first, and one is brought up on each side and rolled round the band en-

circling the waist. This gives a support to the scrotum which has no tendency to slip; it can be adjusted very accurately, never be loose or too tight, and at the same is comfortable to wear. Of course other materials than flannel can be used, and with advantage, for flannel is too irritating for most people's skin. When modified in this way it will no doubt prove very efficient.—*London Lancet*.

IDENTIFICATION OF THE PRINCE IMPERIAL.—The circumstances of the Prince Imperial's death have revived a question which has been somewhat neglected by lawyers and physicians, viz., the importance of the teeth as a means of identification of deceased persons. The late Prince Imperial had been so much disfigured, that identification would have been extremely difficult but that the Prince had had four small cavities in the first molar teeth filled with gold by Dr. Rottenstein of Paris, and had met with a slight accident, in April, 1876, from a blow on the front teeth, which had made it necessary to file the teeth a little, in order to smooth the enamel. These constituted signs which are unalterable, even by ages; and, as careful dentists keep usually a record of such operations, they afford a means of identification which is unerring, and which, as in the present instance, was of great value, and might, under certain circumstances, be of the highest importance.

CARBOLIC ACID IN SHINGLES.—Dr. Lambert reports, in the *Revista Clinica di Bologna*, a case of herpes zoster, or "shingles," which he cured in a single day by means of carbolic acid. He painted carefully the vesicles with the liquid, using a camel-hair brush, and then covered the whole part with a thick layer of cotton-wool. It caused severe burning pain for two hours, after which ease was obtained, and the patient, having received a dose of chloral hydrate, fell asleep, and awoke the next day feeling quite well. Nothing more was done, but the cotton wool was left on for three days. On its removal then the vesicles were all dried up, the crust adhering to the cotton-wool, and the spots that remained were not in the least tender. A saline purgative and a drink containing bicarbonate of soda

were the only medicines taken. No return occurred after two years, and Dr. Lambert thinks this method of treatment may frequently prove of great value.—*Bost. Jour. of Chemist*

THE CINCHONA CURE FOR DRUNKENNESS. Much attention has lately been given to the alleged power of Peruvian bark to destroy the appetite for strong drink, and many cures have been reported from the remedy. Nothing would give us greater satisfaction than to believe in and recommend the reputed remedy. But we lack faith in the specific virtue of it or any other medicinal cure. When the ebriate has come to a resolution to abandon his habits, he seeks a staff to lean on, and finds in the diversion afforded by the bark. Apart from this mental support and the tonic influence of the bitter, there is no healing power in cinchona more than in any other agent of this class, such as calumbo or snake-root. We should be sorry to disappoint any one who has turned away from a bad habit and believed himself radically cured. Thousands upon thousands of men have done the same thing under moral and religious influences, and in an unguarded moment have fallen back. At the same time there are many who have succeeded in throwing off the chains permanently, and gaining perpetual control over their appetites. To do this however, after once becoming a habitual drunkard, requires something more than herbs. It requires a strong will and constant vigilance, enforced by all the aids derivable from moral and religious sources, and the influence of associates and friends. It is not to throw in every help which imagination can devise, but not to depend on such helps. They soon wear out. It will be so with the cinchona cure. It will have its day, and then will come failure and disappointment, and then the remedy will be forgotten. We could wish otherwise, but history will repeat itself.—*Pacific Med. and Surg. Journal*.

Births, Marriages, and Deaths

BIRTHS.

On September 10th, at Toronto, the wife of Dr. H. Burns, of a son.

On September 21st., the wife of Dr. J. J. Cassin, of a daughter.