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Original Communications.

True Membranous Croup.—Tracheotomy—Fatal issue. By RICHARD A. KENNEDY, A.M. M.D. Professor of Anatomy, University of Bishop's College. (Read before the Medico-Chirurgical Society of Montreal, May 22, 1874.)

The following case is reported chiefly from memory, as but few notes were kept. I had not expected that I should read the case, and therefore took no pains to have a full report. I was sent for during the night of the 25th of February last, to see a child, aged four years, suffering from croup.

The previous history showed that the boy had been subject for some days to a cough, which, however, had not been croupy. This night he was suddenly awakened by the cough of croup, which was so prolonged, and of so alarming a nature, that the parents sent immediately for me. On my arrival, the spasm had left him, and the child was quiet, but the breathing was somewhat dry and wheezing. My diagnosis was catarrhal croup.

An emetic of ipecac. and antimony was given, which gave great relief, and afterwards the syr. scillæ co., as an expectorant, with directions to use as an emetic if required. The throat was also well rubbed with a liniment of ammonia and goose oil, and a warm foot bath given.

I saw the child the following day, February 26th. He was almost as well as usual; there had been no return of spasm, but the cough was still hoarse and brassy. At 9 p.m., the same day, was again sent for. Found him very restless, breathing with difficulty and frequent return of cough, which was not so hoarse in character as before, but accompanied with spasmodic efforts to breathe. The dyspnoea was becoming very great, and his whole appearance indicated that the blood was becoming poisoned. Having now no doubt that it was membranous croup, I gave alum emetics frequently, and applied hot fomentations to the throat diligently. The emetics did not produce any beneficial results, nothing but the contents of the stomach were ejected.

I remained with the child during the night. The symptoms increased in severity, and he suffered terribly from dyspnoea. The *alæ nasi* were dilated; breathing was abdominal and very little air entered

the chest during the inspiration; lips and fingers became livid, and the child's struggle for breath was intense.

Considering that death was inevitable in a few hours unless relief could be given by an operation; I advised the parents to allow me to perform tracheotomy, and after some demur gained their consent. The operation was performed at 5 a.m., Feb. 27th, by candle light, Dr. Trenholme assisting me. Chloroform was administered. The incision was made higher up than usual, owing to the extremely large size of the anterior jugular veins, which latter were distended to the size of the little finger, and, as we were afraid that the hæmorrhage would be excessive, I cut immediately above the junction of the veins, so that the amount of blood lost was inconsiderable. The trachea was entered without trouble, being held stationary by a hook, which latter, however, did its office very imperfectly. Some time was lost in inserting the tube, and just as insertion was accomplished, breathing had ceased and life, to all appearance, seemed to be extinct. Artificial inspiration was resorted to, and, after a few moments, we had the satisfaction of seeing respiration return, and the boy breathe easily through the tube. The tube was a double one of silver.

Two hours after the operation, he was lying quiet, but little blood came from the wound, and, excepting occasional efforts to cough, he was quite comfortable. I prescribed aconite, ipecac. and quinine, and a demulcent diet, and as much moisture as possible to be inhaled. I saw him frequently during the day, and was obliged each time to remove the tube and clean it. Toward the latter part of the day I obtained a larger inner tube, which was inserted with benefit.

Feb. 28th.—Respiration slightly hurried, child otherways comfortable and sitting up, playing with toys. Tube fills up frequently with tenacious mucus which is occasionally coughed up through the tube. During the day a piece of what appeared to be false membrane was drawn out by the father, and I had hopes that the operation would be successful. I obtained a small spray producer, and from time to time directed it against the tube, and by this means was enabled to prevent the tube from filling up, as the sputa could without difficulty be forced out. Occasionally, during coughing, frothy mucus would be expelled from the mouth. There was some fever, and the pulse was 96. A large quantity of fluid was drank during the day, principally of milk.

March 1st, 10 a.m.—Respiration more hurried, coughs a great deal, and a large quantity of mucopurulent fluid ejected from tube; pulse 120. Temperature of body increased. On auscultation, found bronchial rales over the entire chest. Dullness on percussion over lower part of both lungs. Prescribed ammon. carb. with ipecac. and seneka.

The inner tube was removed, the other remaining in opening without moving,

7 p.m., same day.—Worse; all symptoms increased in severity; very restless; great thirst; respiration hurried; pulse 140. Tube remains clear, but a large quantity of mucus expelled. Dullness on percussion increased and extended upwards.

On auscultation, moist rales heard over both sides.

From this out the child continued to grow worse. Became exceedingly restless; refused his medicine and beef tea, but would drink milk. Dyspnoea became greater till death closed the scene at 5 a.m., next morning.

The only post-mortem examination made was upon the throat; shreds of false membrane were still adherent to the upper part of the trachea, and the glottis and epiglottis were swollen and thickened. The wound of the operation looked well, and there had been but little inflammatory action on the adjacent tissue. Death must have resulted from the ensuing broncho pneumonia, and perhaps this had existed previous to the operation

The tracheotomy did not save life, it prolonged life and possibly made death easier.

Another child was taken down in the same manner in the same house during my attendance on the above case. This latter I actively treated with emetics of sulphate of copper, which I now think is to be preferred to any other emetic in croup. In addition, small doses of ant. tart. and hydrarg. were given frequently with an expectorant of ipecac. and seneka, while externally the attendant nurse rubbed in the liniment of ammonia so diligently as to produce blistering, which I believe was also beneficial. This child recovered. Since the above case was treated, I have seen an article in the American Journal of the Medical Sciences for April, 1873, in which Dr. Ehrhardt, of Illinois, cites four cases, one of which was diphtheria, the other croup. Tracheotomy was performed in all with the result of saving two of the children. The emetic used in each croup case was sulphate of copper. The chief medical treatment being chlorate of potash, a teaspoonful of a saturated solution every hour, and adding quinine and expectorants as required.

Three Cases of True Membranous Croup, or Pseudo-Membranous Laryngitis. Tracheotomy performed in one Case. Fatal issue in all, by FRANCIS W. CAMPBELL, A.M., M.D., L.R.C.P., Lond., Professor of Physiology, University of Bishop's College, Montreal, (read before the Medico-Chirurgical Society of Montreal, May 22, 1874.)

On the afternoon of Nov. 27, 1873, I was called to see the little child, aged 2½ years, of Mr. C. W., a gentleman of wealth and position. I found the infant on its mother's lap; tossing about in its endeavors to get breath, with that characteristic whistling sound, indicative of the real character of the disease. I at once placed the child in a warm bath, and gave it a mixture of compound syrup of squills, ipecac and Flemings tincture of aconite, which was to be given every half hour till my return. At 6 p.m., I visited the child, and met Dr. Major in consultation; there was apparently some amelioration in the symptoms—the cough was at times a little broken; it had vomited several times, and the skin was acting freely. I suggested the lime vapor bath, which was agreed to by Dr. Major, and having set this in operation, I left. At 9 p.m., I returned and found the child decidedly worse, all the symptoms were aggravated. Dr. R. P. Howard and Dr. Major met me in consultation, when the following mixture was ordered:—

Potas bromid,	3 iij.
Potas iod.,	ʒ i.
Senek fld. ext., (Tildens)	ʒ ii.
Vinum ipecac,	ʒ ii.
Belladonna fld. ext.,	gtt ix.
Tinct opii, co.,	ʒ v.
Aquæ,	ʒ viii.

A dessert spoonful every two hours.

Cold cloths were instructed to be kept constantly around the throat, and with a view of promoting if possible, the expulsion of the false membrane, a half grain of sulphate of copper was ordered, to be given every fifteen minutes. I remained, and carried out the treatment throughout the entire night. At first, the cold applications and the action of the sulphate of copper (which did its work most effectually), seemed to afford marked relief, so much so indeed, that several friends, who had intended remaining all night, went home, satisfied that a change for the better had occurred. About 3 a.m., (28th,) the character of the breathing again rapidly became stridulous. At 4 a.m., it was impossible for the child to remain in one position for a moment, so fearfully

did it struggle for breath. At 5 a.m., it became insensible, and shortly after died.

The family in which this case occurred is large; all the children have been subject to severe attacks of bronchitis, but this is the only case of croup which has taken place among them.

Case 2. I was sent for on 3rd of April last, to visit Alice Louise, child of Mr. Murphy, plumber, residing on Cemetery street. The child was hot and feverish, with a hoarse, croupal cough, brown tongue, and pulse of 120. She complained of uneasiness over the larynx, but the breathing, although somewhat husky, was perfectly free. On auscultating the chest, which was done with difficulty, no signs which could be deemed reliable, as indicating extension of the inflammation down the bronchi, could be heard; I directed sinapisms to be applied to the front of the chest, extending them over the larynx, and to be repeated every four hours, and the following mixture:—

Potas bromid,	3 ii.
Syr scillæ co.,	̄ iss.
Vin Ipecac,	3 ii.
Aquæ ad,	̄ viii.

A dessert spoonful every two hours.

The child to be removed to an inner room, to avoid the cold air, to which it was exposed, from a door which opened directly from a gallery into the room in which I saw it.

April 4. During the night I was sent for, but being engaged at an accouchment, did not see it till early this morning, when I found all the symptoms of true croup present. I then applied hot fomentations and finally hot linseed poultices over the trachea, had the air of the room rendered moist, and gave vinum Ipecac as an emetic. It acted freely, but without any apparent relief to the symptoms, and at 8 p.m. the child was in painful struggles to get breath, at 9.30 p.m., it died.

Case 3. On the morning of the 3rd of May, 1874, I was requested by Mr. Y., residing on Courville street, to see his little child, aged 2 years and 17 days. The case was not mentioned as being urgent, and I did not reach the house till well on in the day, when the mother told me that three days previously the child had begun to cough, and although it nearly always was of a croupal character, yet it sometimes seemed broken; that the previous day she had seemed much improved, but with a sudden change in the weather the previous evening, the cough again became hard, and during the night the child had been very restless, sleeping but very little. I found

the little sufferer on her mother's lap, tolerably quiet, spasms of coughing occurring every few minutes; the cough having a loud, hollow sound; the breathing was hurried, 30 in a minute, and was whistling and dry in character; the larynx being forcibly elevated and depressed with each respiration. The child's face had a distressed look; the eyes were prominent; considerable heat of skin, and but little moisture. Pulse 130, and irregular in volume. I attempted to auscultate the chest, but as the child was fidgety, and began crying, I made nothing whatever of my examination. I ordered mustard over the trachea, to be followed by hot linseed poultices, and the air of the room to be made moist, also the following mixture:—

Syr scillæ Co.,	̄ iss.
Vinum Ipecac,	3 iii.
Senek Fld. Ext,	3 iv.
Potas bromid,	3 ii.
Aquæ ad,	̄ viii.

A dessert spoonful every two hours.

Later in the evening I returned, and was informed that after each dose of the mixture, the child had vomited freely, bringing up large quantities of thick yellow matter; that the cough was decidedly broken and not nearly as frequent, and that several times it seemed more playful. It had also slept at intervals. I remained about half an hour, and the only improvement noticeable to me was that the paroxysms of cough were not so frequent or so long, but they were still croupal in character. This latter fact, the family attributed to the fact that the last dose of the mixture, given a short time previous to my visit, had not produced emesis. The respirations were as frequent, and of the same character, and the pulse was higher than at my previous visit. I directed that the child should be given Ipecacuanha wine in doses sufficient to produce emesis, provided the mixture had lost its power of doing so; that the temperature of the room should be raised to 70° Fahr., and that another bucket of hot water should be placed in the room, into which hot bricks should be plunged every 15 minutes, with a view of increasing the moisture of the atmosphere.

May 3rd, 1874.—Shortly after 4 o'clock this morning I was aroused by the child's father, who told me he was fearful that the child was dying—that neither the mixture or the Ipecacuanha wine had had any effect. I suggested a consultation, and Dr. Finnie met me at 6 a.m. We at once saw that the child was dying, and that internal remedies were

useless. Dr. Finnie suggested tracheotomy, and although I felt from the history of the operation not only in this city, but on this continent, that the chance of its success was almost *nil*, yet as it was the only chance the child had we decided to recommend it. This we did, and the consent of the parents having been obtained, we proceeded to make preparations for the operation. So rapidly did the course of the disease progress to a final issue, that by the time everything was in readiness it was admitted by all that a very few minutes would terminate the child's life. The child being placed on a table, and the shoulders elevated so as to allow the head to fall back, and thus bring the trachea into prominence, I proceeded to cut down. A good deal of trouble was experienced from a vein or two which were cut across, but torsion soon stopped the bleeding. The trachea being reached some difficulty was had in steadying it, for when pressure on the rings was made by the knife it rolled from side to side—a tenaculum failed to steady it; this was finally accomplished by steadying it by a finger on each side. I then cut three rings, and was bespattered by blood and mucus—for an instant the child seemed lifeless, but the tube being introduced respiration was resumed. The relief was most marked, and apparently from the borders of the grave the child was brought back to have another chance for its life. Everything being securely fixed, the child was placed in bed, and was soon asleep. The temperature of the room was raised to 80° and moisture kept up. I remained till 9 a.m., and left the child sleeping comfortably, having previously ordered the following:—

Quin Sulph.,	gr xvi
Tr Ferri Mur,	ʒ ii
Potas chl	ʒ ss
Vinum Ipecac,	ʒ ii
Syr Simp.	ʒ iss
Aquae, ad	ʒ iv

A tea spoonful every two hours.

12 m.—Child very comfortable—slept a good deal. Respirations 24 per minute. Pulse 160, full and irregular in volume, has taken fluids, beef tea, &c., with avidity. Is cheerful, has noticed some of its play things; bowels moved, tube cleaned only once, and is now quite free.

An ingenious arrangement was adopted for keeping up the moisture. A small hose was attached to a boiler in the kitchen, and conveyed by means of this rubber tubing into the bedroom, into

which it discharged large volumes of steam. The room in this way was kept very moist—temperature of bedroom, 84 F.

4 P.M.—Still the same. A student in attendance, who has cleaned the tube three times. Respiration 24, pulse 160, temperature of room 86 F. and moist. Auscultation gives respiratory murmur quite clear. Takes food well.

9 p.m.—Same report.

May 4.—Student reports the child somewhat restless during the night—the tube requiring cleaning about every half hour. Respiratory murmur still clear. Bowels moved; pulse 180 and very full, still takes food with great avidity.

2 p.m.—Sent for in great haste, as child had a severe convulsion—had another before I reached the house—found her comatose, both pupils dilated, respirations 38 per minute, pulse small and impossible to count, large accumulation of mucus in bronchial tubes. Child never rallied, but passed quietly away at 3.30 p.m.

Progress of Medical Science.

ABSTRACT OF A LECTURE ON CHLORAL AS AN ANÆSTHETIC DURING LABOUR.

By W. S. PLAYFAIR, M. D., Prof. of Obstetric Medicine in King's College, Physician for Diseases of Women and Children to King's College Hospital, and Examiner in Midwifery to the Royal College of Physicians.

“The means at our disposal for lessening the sufferings of our patients during labour must always be a subject of great practical interest to the accoucheur. The administration of chloroform during the second stage has become so established a custom among many, that it is perhaps hardly necessary to say much with regard to it. The more experience, however, I have of its use, the less I feel bound to say, do I like it as an anæsthetic during labour; and this, not because it does too little, but on account of its tendency to do more than we wish. While, in certain cases, when given with judgment, only during the pains, and not until these have become strong and forcing, it answers admirably, soothing the patient's suffering without retarding her labour or producing complete anæsthesia; in others, it has an unquestionable tendency to diminish the force and frequency of the uterine contractions. I know not what may have been the experience of others, but my own certainly is that in a large number of cases it has a very marked effect in diminishing the strength of the pains, and thereby very materially lengthening the continuance of the labour. Over and over again,

when the administration of chloroform has been commenced, I have observed the character of the pains completely to alter, and again recover their former efficiency as soon as the inhalation was suspended. Besides this, I have no doubt that a very continuous use of chloroform during labour has a marked effect in predisposing to post partum hemorrhage, inasmuch as the tendency to undue relaxations of the uterine fibres continues for some time after the birth of the child. Although I by no means intend by these remarks to advise you not to use chloroform during labour, I certainly do think that it ought to be given with a greater degree of caution, and perhaps more sparingly, than the recommendations in many of our text-books would lead you to believe to be needful. The susceptibility of patients to its action seems to vary much, and therefore it is all the more necessary that its effects should be carefully watched in each individual case, and the amount administered regulated accordingly.

"While, in my judgment, chloroform is apt to be too freely and incautiously used, the administration of chloral as a means of lessening the pains of labour is, I think by no means as yet appreciated at its proper value. It has this immense advantage over chloroform, that it does not seem to diminish the strength and intensity of the pains, while it very markedly diminishes their painfulness. It has also another great recommendation, that it is chiefly applicable at a period when we would not think of administering chloroform—towards the termination of the first stage of labour, before the complete dilatation of the os, and when the sharp gridding pains perhaps produce more suffering and are less easily borne than the more forcing pains of a later stage. There is a type of labor very common, especially in women of a highly-developed nervous organization, such as constitute a large proportion of our patients among the higher classes, in which I have found it to be specially valuable. In these, before the rupture of the membranes and the complete dilatation of the cervix, the pains are very severe, but short and ineffective, chiefly limited to the back, and producing little or no effect in dilating the os. Hours and hours really intense agony often elapse, until the patient is wearied and exhausted by her fruitless sufferings. In cases such as these, a common and very useful practice has been to administer a considerable opiate, so as to produce some hours of refreshing sleep, after which we expect the labour to recommence with fresh vigour and effect. The disadvantage of this plan, however, is that during the action of the remedy the labour is suspended, and much time thus lost. If, however, chloral is administered instead of the opiate ordinarily employed, the probabilities are that the same refreshing rest will be obtained without any suspension of the pains or protraction of the labour. The character of the uterine contractions will be observed to alter; they will become steady and useful, but they are not suspended. Another condition frequently associated with the former is rigidity and spasm of the cervix. Very generally in this class of cases the cervix is thin and rigid, with a sharp edge. Soon after the chloral has taken effect the tissues

seem to relax, and I have not unfrequently observed a thin os, which had remained unaltered in character for many hours, dilate rapidly under the influence of the remedy, far more so than when chloroform is inhaled for this indication. It is not however, only in cases of this kind, which may be classed among abnormal labours, that the use of the drug is of value, although it finds perhaps in them a more special application. It may, I think, be very generally and advantageously exhibited in perfectly natural labour, for the specific purpose of lessening the sufferings of the patient. When judiciously given the patient falls into a drowsy state, not quite asleep but nearly so. She is roused as a pain begins, but suffers comparatively little; and experienced women, who have the recollection of former labours to guide them, bear strong witness to the immense relief thus obtained. I have given the remedy in this way for the past two years in most cases I have attended, and I have no reason to think that any bad effects have followed its administration. I have very carefully watched the intensity of the contractions, and I have not the least ground for thinking that it has any effect in diminishing either their frequency or their force.

"The way I give the drug is as follows: I order a six-ounce mixture, containing a drachm and a half of the hydrate of chloral. When the pains are becoming severe, and I deem it advisable to employ the anæsthetic, which is generally not until the first stage of labour is approaching completion, I give one-sixth part of the mixture—i. e., fifteen grains of chloral. This I repeat in about twenty minutes; and usually after the second dose enough has been taken to bring the patient sufficiently under the influence of the remedy. Its further administration must now be regulated by its effects. If the patient is drowsy and relieved, a third dose need not be given for three-quarters of an hour or an hour; and then half the quantity will probably suffice to keep the patient in a sufficiently somnolent state. It is seldom necessary to give more than a third dose; and I have never given more than a drachm of chloral during the entire labour. In this way, lessening the quantity after the second dose, and increasing the intervals between their administration, a full and sufficient effect can usually be kept for many hours. I feel certain that any who give this method a fair trial will appreciate its value.

"The exhibition of chloral in this way is no novelty. It has, I believe, been recommended more than once in our journals; but, so far as I know, it has never come into anything like general use as an anæsthetic. Bear in mind that it need not at all interfere with the exhibition of chloroform. When the pains get strong and forcing, that may be inhaled just as if chloral had not been given, only a smaller quantity will probably suffice. As our patients suffer less, they are also less urgent in their demands for the commencement of the chloroform inhalation; and thus there will be less likelihood of those evils I have mentioned to you being produced."—*Lancet*, Feb. 21, 1874.

INTERCOSTAL NEURALGIA IN WOMEN.

By J. MILNER FOTHERGILL, M.D., M.R.C.P.

There is no more marked form of disease than this particular form of neuralgia. It is commonly met with among the out-patients of every medical charity, and even in private practice. Indeed, it is the commonest affection met with among women of that class where neuralgia, unconnected with diathesis, might fairly be expected—viz., among those where nutrition is defective: an essential in the production of neuralgia. It belongs to the productive period of woman's existence, and is but comparatively rarely seen after that time, and never, in my experience, before it. It is a troublesome and intractable malady unless approached vigorously and with relation to those disturbances of the reproductive organs with which it is so intimately associated. In almost every instance leucorrhœa is present, usually either with amenorrhœa or menorrhagia: and in those cases which are not accompanied by leucorrhœa, the woman is usually suckling.

The pain is truly neuralgic, that is, according to Anstie, it comes in recurrent waves, or gusts, and is one-sided. I have never seen a case of this form of neuralgia where the pain was on both sides, and but rarely where it was on the right side. It is a left-side pain essentially. It is commonly called "pain in the side," and its truly neuralgic character is overlooked. A patient suffering from this affection gives a history to the following effect:—She is weak and feeble, with black spots before her eyes, and has pain in her side and betwixt her shoulders, and very commonly dyspepsia, or constipation. In addition to this she admits more or less reluctantly that she is much troubled with leucorrhœa, and usually has some uterine derangement. In the cases where this is not the case, she is suckling. In appearance she usually presents a debilitated aspect, and very commonly is a dark and sallow woman of lymphatic temperament. But by no means necessarily so; and women of a totally different character are found as sufferers from this feminine scourge. The tongue is usually clean, bright, and often silvery, without change of size, except in advanced or aggravated cases, when it is swollen and indented by the pressure of the teeth. She complains of pain in the side and betwixt the shoulders, and the painful spots are very tender upon pressure. In reality, these are the tender spots of Valleix; and one is found over or near the left apex, and the other at the posterior spinal rootlet of the nerve. The nerve usually affected is the sixth intercostal. Such is the malady in its ordinary aspect, and its features are singularly unvarying; so much so, indeed, that when "pain in the side" is complained of, the symptoms can be rapidly run up, often much to the patient's astonishment. This is specially the case as to the uterine connections, which are often carefully concealed, and only admitted when the question is pressed.

As a rule it may be said these cases are found among the married, and among servants who work hard and take little care of themselves; indeed, they often scarcely know how, if they had the time, to

do so. In rare cases women past the menopause have this ailment, commonly with its ordinary accompaniment leucorrhœa, at other times without it. It is a disease of debility whenever met, and is free from any association with those affections, syphilis and malaria, so productive of neuralgia. At times it is found in girls who are decidedly anemic, and verging upon chlorosis: and tedious and ineffective is the treatment where the relations and concomitants of the neuralgia are overlooked, either from ignorance or carelessness.

The prognosis of the disease, like that of neuralgia generally, is good; but the progress is much affected by the treatment, and that again depends much on the knowledge of the ailment possessed by the medical adviser.

Treatment.—This must be conducted partly on general principles, partly in reference to the special indications. As to the first, we must remember the other two characteristics of genuine neuralgia given by Anstie—viz., that it is aggravated by all depressing agents and by increasing debility, and also that it is relieved by general improvement of the condition, and by the agents which tend to induce the latter change. My usual rule has been to give a combination of stimulants and tonics, and specially carbonate of ammonia with the ammonio-citrate of iron in an infusion of quassia. In a little time this may be advantageously changed for sulphate of quinine, muriate of iron and quassia. Recently, however, I have accompanied my friend Professor Ferrier to the West London Hospital and compared notes with him. His favorite treatment is to give the well-known mixture of gentian and rhubarb. In many cases where the gastric symptoms are marked, this plan was unquestionably successful; but in others the plan adopted by myself is more effective. The change, however, is almost certainly effective. In addition to this exhibition of internal remedies, belladonna plasters and the local application of mustard have been tried; but of course it is difficult to say with what effect, as other measures were combined with them.

The absolutely necessary part of the treatment is the attention of the local discharge. Whether this discharge is vaginal or uterine I do not know, not having investigated the point. The use of the cold hip bath, or where this is impracticable, or is badly borne, cold water bathings of the parts night and morning are necessary. To this may be added in more obstinate cases injections, either of cold water or the ordinary astringent mixtures. Without this local treatment is properly followed out the progress of the case will be uncertain and disappointing.

Where there is menorrhagia the usual plans of treatment of that affection may be blended with the measures given above. The remedies indicated in these cases are, however, rather of an astringent nature; their constipating effects being avoided by the administration of laxatives. In all cases, indeed, the bowels should be attended to; and for this purpose aloes are well suited from their action on the hemorrhoidal vessels. The action of the skirts hanging from the waist and squeezing the contents of

the abdomen into the pelvis should not be forgotten; and every thing calculated to produce pelvic congestion should be avoided.

Where the affection is associated with suckling, the child should be weaned forthwith, or, at least, the breast should be reserved for the night.—*Obstetrical Journal of Great Britain,*

TREATMENT OF FUNCTIONAL DERANGEMENT OF THE LIVER.

Dr. Charles Murchison, in one of his Croonian Lectures, gives the following advice on this subject:—

First, in regard to *diet*, much more is to be expected from the careful regulation of diet than from physic. We ought to remember that the hepatic derangement of lithæmia may exist for years, and that it may be cured by a careful attention to diet only, but if neglected may go on to gout. Over-eating, especially of rich food, must be interdicted and above all saccharine and oleaginous cooked dishes. Even bread may have to be given up by the patient. Any idiosyncrasy must be ascertained. A simple diet of stale bread, fish, tea, etc., will be found best. The derangement may be due to over-much both of nitrogenous and non-nitrogenous foods, and it may be necessary to order a minimum only of both kinds. The chief meal of the day may have to be taken in the morning. Diluents, such as the mineral waters, may prove useful. Even greater caution should be exercised in recommending alcoholic drinks, especially malt liquors; many patients under these circumstances do better without stimulants at all. Alcoholic drinks, in amounts falling far short of affecting the brain, may undermine the health by their effects on the liver. The effect of sudden and complete abstinence is not so serious.

Secondly, a free supply of *oxygen* is, next to diet, highly important in the treatment of functional diseases of the liver. There is no doubt that exercise quickens the circulation, introduces more oxygen into the system, and operates beneficially on lithæmia. Observations have shown the value of sea-air, and patients with hepatic derangements and lithæmia will, especially under favorable circumstances, derive advantage from residence on the coast.

Aperients and cholagogues are of value in many cases, whether constipation is present or not. Aperients carry off not only bile but fluid from the intermediate circulation. The aperient salts are chiefly used. Certain other aperients have long had a reputation, as cholagogues, among which mercury stands pre-eminently. At the present day mercury has, however, lost much of its reputation, especially as a cholagogue. A practitioner gives a mercurial, and finds more bile in the stools and his patient relieved. A physiologist ties the common bile-duct, makes a fistula, and finds that less bile is discharged after the administration of mercury. The results of such experiments have indeed been contradictory. The general effect has been to discredit the cholagogue action of calomel very much. On the other hand,

it has been urged that the results of such experiments do not apply either to man or to the diseased state of the liver. Now, much of the difference of opinion may be reconciled if we remember the osmotic circulation in the abdomen previously alluded to. A large proportion of the bile which enters the bowel is reabsorbed and carried back to the liver. Mercury and some other drugs produce bilious stools because they sweep away the bile before it is absorbed; and it is for this very reason that they are to be found at the bottom of Röhrig's list of medicines which increase the flow of bile from the common duct. It would appear, therefore, that mercury is a true cholagogue, and that more than if it were a mere stimulant of the liver, and thereby induced congestion. It may also act on the gall-bladder. But there is reason to believe that mercury is of use in other functional diseases of the liver unattended with biliousness. Patients suffering from such diseases continually confess this. Mercury may indeed be useful for the very same reason that it is useless in promoting the healing process, namely, by helping disintegration. It is perhaps for the same reason valuable in some cases of crup and in constitutional syphilis. Be this as it may, the clinical evidence in favor of mercury is overwhelming. Podophyllin acts much like mercury, but it has probably some affinity for the small intestine, and gripes more than mercury. Jalap, senna, etc., are all valuable. Röhrig seems to consider them true cholagogues. Coleicum has some effect in this way; taraxacum probably acts mainly as a mild aperient.

Alkalies, next to aperients, are the most useful drugs in functional derangements of the liver, especially a combination of alkaline salts. The waters of Vichy, Vals, and Ems are valuable for the same reason. The beneficial effects of alkalies are not due to the neutralization of acidity or of lithic acid, but to their influence upon the pathological state on which lithæmia depends. The administration of alkalies in lithæmia is, as a rule, well born, but it should be occasionally interrupted.

Chloride of ammonium, mineral acids, tonics, and opium may be used in these cases; but tonics should be given with the greatest possible caution, otherwise they may do more harm than good.

COUGH FROM ELONGATED UVULA.

Dr. C. B. Garrett writes to the *Lancet*:—It is no uncommon thing to find a person suffering from harassing cough, his health enfeebled, spirits depressed, appetite diminished, and body emaciated, whom no remedies have more than slightly relieved, and yet all owing to the local irritation caused by an elongated uvula. I feel perfectly convinced that in many instances it arouses the tubercular diathesis, and leads on to the development of phthisis, if not of other formidable affections. Cases are constantly presenting themselves to me of congestion of the lungs, which are clearly traceable to the existing agency of this lengthened appendage.

A person will tell you that he has a distressing, barking cough, especially in the morning, much aggravated by E. and N. E. winds, till a little secretion commences in the larynx, and he can "bring up the phlegm," and this may disturb him more or less during the day and night. There is also usually a sensation of there being a something at the back of the throat to be swallowed. This is the prolonged uvula, which may often be seen with its apex lying on the tongue, after the fashion of a foot. I have often witnessed instances of a thin, long uvula being actually drawn up out of sight, as it were, by the action of the muscles in suddenly opening the mouth, and disclosing its longitude only by keeping the depressor on the tongue till the muscles were tired. The soft palate soon becomes flabby, the arches lax, and the fauces red and puffy. Now comes the second stage. The irritation and congestion travel onwards down the windpipe, the mucous membrane of which becomes thickened, and so cushions up the interior of the tube that the volume of air inhaled in natural inspiration is insufficient to inflate the lungs; the bronchial tubes collapse; the pulmonary blood-vessels become gorged, and congestion (our third stage) is established. The breathing becomes affected; the heart joins in the *melée*, with throbbings, even occasionally intermitting in its beats. With such unquiet neighbors the digestive system sympathizes, with loss of appetite, possibly retching (in a measure attributable to the irritation in the palate, etc.), flatulence, constipation and other systems of disturbed digestive functions. The urine throws down a sediment of lithate of ammonia, often clouded with mucus, and altogether there is a general disturbance of the whole system. Nor do the brain and nerves escape. Deficiency of memory, incapability of mental application, dullness of intellect, gloomy forebodings, abhorrence of society, occasional vertigo, restless, dreaming nights and staggering gait complete the category of doleful consequences arising, in the first place, from an elongated uvula!

Treatment is operative or medicinal, or both conjoined.

RECURRENT HERPES.

There are two striking differences of character in herpes; the one is that the eruption, as a general rule, is never repeated; the other is, that it recurs frequently. These extremes of difference, regarding the disease as a neurosis, appear to me to be due to the part or extent of the nerve implicated, and have induced me to group the various forms of herpes into such as are consequent on a morbid state of the trunk of the nerve, and such as are consequent on a morbid state of its peripheral branches. Herpes zoster is an example of an affection of the trunk of a nerve; and herpes labialis, progenerialis, &c., of its peripheral branches; and it is far from difficult to conceive that a mere temporary condition of the surface, or an emotional cause, may determine the one, while a deeply penetrating or deep-seated cause may be necessary for the development

of the other. Some degree of light may be thrown upon the subject by the narration of the following case:—

A little boy, aged five years, was brought to me in March, 1868, with a small patch of herpes on the left cheek, apparently the manifestation of a state of irritation of a branch of the superior maxillary nerve. The patch was single, about one inch in diameter, brightly red, and dotted over with a cluster of imperfectly-developed vesicles, which ended, after a few days, in small, yellow scabs. The symptoms accompanying the eruption were itching, heat, and a little smarting, and the whole duration of the affection was five days. I prescribed for him the syrup of phosphate of iron, and ordered that the eruption should be dusted over with a powder of oxide of zinc, calamine, and starch, with a little camphor.

In February, 1870, the little fellow was brought to me a second time, with two patches instead of one, but of perfectly identical appearance and nature, and on the same cheek; one being situated on the zygoma, the other near the angle of the mouth, and both within the region of distribution of the superior maxillary nerve. The eruption first appeared on Tuesday; he was brought to me on the Wednesday, and two days later the patches were fading and disappearing.

But the interesting feature of the case was the medical history of the child. For two years he had been the subject of a repetition of a similar eruption on the same cheek, every two or three months: appearing in the same way, disappearing quickly, and giving rise to scarcely any inconvenience; and he was brought to me, not on account of any suffering attending the disorder, but with the hope that I might suggest a means of preventing the continual recurrence of the affection. On inquiring carefully into the habits of the child, with the view to discover a possible cause for the morbid phenomenon, I ascertained that he was remarkably excitable, and that when crossed he would suddenly give way to violent fits of passion; such an occurrence had happened on Sunday night, somewhere about forty hours before the appearance of the eruption, and his mother had previously noticed that other attacks had followed upon these violent fits of nervous excitement. There was no other cause detectible, and I am therefore led to the conclusion that in this instance the cause of the herpes was an emotional stimulus of the brain communicated to the peripheral extremity of certain filaments of one of the divisions of the fifth pair of nerves.

In herpes præputialis it has been surmised that some specific cause might probably be present, but this explanation would be groundless in the similarly fleeting forms of herpes that occur upon the face. Herpes from irritation of the peripheral nerve—plexuses of the skin—is not only remarkable for its tendency to recur at intervals, but also for the small extent of the cutaneous inflammation, and furthermore for the absence of a rigorous respect of the middle line. A gentleman now before me has a patch of herpes on the middle line of the forehead at

the root of the nose. The patch is no bigger than a fourpenny piece, but it encroaches pretty equally on both sides; and I have frequently observed that, in a case of herpes zoster, there has been an intrusion of the eruption beyond the middle line, apparently due to intercommunication of the peripheral nerve—plexuses. Near the extremity of the eyebrow of the same gentleman is a small encrusted patch of herpes, now a week old,—that at the root of the nose having appeared within twenty-four hours. Then there is the stain of a previous patch of herpes at the inner extremity of the same eyebrow, and two similar stains on the nose near the middle line. But all these patches have appeared separately, chiefly on the right side of the face, and their average duration has been ten days.

He tells me that he has been tormented with this little annoyance for seven years, and that it recurs pretty regularly six times in the year. The appearance of two patches within the limit of a week had somewhat alarmed him; and that it was which had brought him to me. I found him somewhat debilitated, with a pale tongue and pale conjunctiva; he had been a good deal overworked for some time past, and stood in need of the remedy which I prescribed for him, namely, citrate of iron and quinine. There was no apparent explanation of the selection by the morbid process of the right side of the face.—*Erasmus Wilson, in Journal of Cutaneous Medicines.*

OBSERVATIONS ON PURPURA.

BY DR. H. BROWN.

The subject of Purpura has from time to time occupied some attention in systematic medical treatises as well as in those works devoted to Dermatology, properly so called, and it presents many features of interest and a wide field for speculation. Some writers have not failed to take advantage of the opportunities thus offered; but, as yet, very little light has been thrown upon the causes of this affection. If we examine carefully the symptoms, and inquire minutely into the causes of scurvy, and then ask ourselves the question—How have scurvy and purpura come to stand in such close relation to each other? we get not a little confounded.

To call purpura *and* scurvy may be all very well; but it should not be imagined that the causes are the same which produce it and scurvy, properly so called. I confess I cannot find any strong resemblance between purpura and scurvy. The causes which produce scurvy are always constant, or nearly so, while purpura, on the other hand, occurs without any well-ascertained cause, so frequently, and under such opposite conditions, that the etiology of this affection is thereby rendered most perplexing and unsatisfactory. After all that has been written, the causes of purpura are still involved in obscurity.

Purpura and scurvy are two affections which differ so much in their nature, and are brought about by causes so widely at variance, that I cannot

consider them more than slightly allied to each other. We may class them under the head of "*general diseases*," and consider the most fitting place for them to be that of juxtaposition. But what comes of all our ideas of similarity when we have to treat these cases individually? Antiscorbutics have little effect in purpura; but some vegetables, without any medicines at all, will cure a patient of scurvy.

Sponginess of the gums and the occurrence of petechiæ are not to be considered pathognomonic of either. In many other instances these symptoms are present without purpura, or even a trace of discernible scurvy. The late Dr. Hillier, writing on the subject, has well said, "With the advance of medical knowledge, it is very likely that the cases even now classed together under the name of purpura, will be further distributed under several distinct categories according to their real pathological character."

Whatever change the blood may undergo in purpura, it is evident the capillaries of the mucous membranes and skin also undergo some alteration. Parkes has recorded cases in which iron was present in the blood in unusually large quantities in purpuric disease. If this be so, it is strong evidence that upon the deficiency of the iron salt of the blood, purpura does not depend. Again, in other cases, fibrin has not been found deficient, even although the blood is less coagulable than in other diseased states of the system. Upon this, however, little need be said, since we know so little, even in this advanced age, of the changes which may be readily effected, in short spaces of time, in the whole volume of the blood constituents under certain conditions. According to Fuchs, whose authority is quoted by the greatest Dermatologist of our age, Hebra, those "who are ill-fed, and who live in damp, close, and cold dwellings," are especially the subjects of purpura.

Suppose we grant this, and even more, how is it that so few cases occur in Great Britain and Ireland? Very few medical men have had under their charge more than a few isolated cases of purpura, and some also have not, in a long series of years, seen a single case of true purpura hæmorrhagica. Hebra has treated the subject of purpura, like all other authors, with an evident feeling of reticence. He cannot reconcile conflicting points; and with blood changes, and capillary alterations cropping up at every stride of imagination, he is at last obliged to confess—"Hence it is most probable that the circumstances enumerated above have but little influence in producing purpura, and that they have been brought forward only because they are well-known causes of so nearly related a disease as scurvy." This is certainly open-minded; but throughout Hebra's article, no light is shed upon this obscure affection. To assign "*telluric influence*" as a cause of purpura (and that only insinuatingly) is just making a worse job of a badly-constructed hypothesis. I have gone over everything of importance that I could find at all bearing upon the subject of purpura, and I confess I am now as much "at sea" as ever.

It is not very pleasant to have such a story to narrate; but let any man carefully examine what has been written upon the subject, and he will candidly confess that so far as regards the etiology of purpura, we know nothing at all worthy of being described under the heading "cause." The diagnosis is simple, and the results, in many cases, are too well mapped out.

The *treatment* is not always so well understood. Why some order lime juice, lemon juice, or citric acid, I cannot understand.

These we know are useful in scurvy; but they are next to useless in purpura.

Dr. Hillier, in his article on purpura, in "Reynold's System of Medicine," offers some good remarks at the beginning of "treatment;" but there is nothing striking throughout this recent article. I am afraid very few will now think of bleeding a purpuric patient. Salines may be of use, as Miller pointed out long since; but their use is very doubtful; and calomel and jalap may not be without some good properties; but active catharsis in purpura is, to say the least, open to grave question. Iron is unquestionably an excellent remedy; but it is often overrated. I think thirty drops of the tincture quite sufficient for one dose, and this dose can hardly be repeated oftener (if the iron be continued for some time) than every four hours. Few patients could take half an ounce of the tincture of iron in the twenty-four hours, for some days, without much inconvenience. Indeed it is difficult to understand how large doses can be administered for days together without untoward results. The large doses of turpentine, recommended by the late Dr. Neligan in this affection, could hardly prove of such signal benefit as to warrant their frequent use. How a patient, say a young lady, could be prevailed upon to swallow an ounce, or an ounce and a-half of turpentine, is more than I can comprehend. Larch bark tincture, on the other hand, in puerile doses, and a host of other remedies, have been recommended. Ergot of rye is undoubtedly a most useful and energetic stimulant; and in a work like the "System of Medicine," I cannot account for the omission of this potent drug.

Bark, or quinine, with the mineral acids, and an occasional purgative of a mild description, with judiciously-arranged dietetic treatment, offer the fairest chances of success in the treatment of purpura. As a hæmostatic, ergot, in the form of tincture, liquor, or *ergotine*, is almost invaluable in this, as well as in many other affections, complicated with capillary hæmorrhage. Tannin, and other astringents, may be useful in purpura; but the use of such remedies cannot be continued for long periods without much detriment.

Hebra has said that "no universal rules can be given on the subject" of treatment of purpura.

This is very evident. The causes are not always alike that operate (so far as we can ascertain) in the production of the diseased state called purpura. At one time, the ill-fed, ill-clad, and miserable inhabitant of some wretched abode is the subject of purpuric disease; at another, the wealthy inmate of

some cosy dwelling is appointed to undergo the varying vicissitudes of this affection. Why, it is difficult to say; nay, is it not almost impossible? Apart from blood change, or changes, I cannot doubt but that the capillary vessels are the chief seats of the disordered condition; and in whatever way the lesions or changes in these vessels are brought about, there is an evident want of that tonicity upon which depends the proper carrying-on of those vital functions with which every organ, blood-vessel, nerve, or organic constituent of the bodily frame at first become possessed, and upon the continuance of which health must ever depend.

In these remarks I have purposely avoided entering into the varieties of purpura, and many other points in connection with its etiology, as well as the treatment of the disease. I have also passed by many interesting matters in connection with the case given above, and so well described by Dr. Lindsay, to whose kindness I am indebted for the history, which I now present to the notice of the profession.—*Journal of Cutaneous Medicines.*

THE TREATMENT OF SYPHILIS.

The following very practical and sensible remarks of Dr. J. Hutchinson, of London, in the *British Medical Journal*, merit careful reading.

"The antidotal power of mercury in syphilis is in no degree of relationship to its full physiological influence; and the best cures are often those made most quietly. Now, these principles being kept in view, I do not know that there is much to be added as to detail. Begin early; continue long; do not salivate; such would be my rules. I have strong preference for one kind of mercurial preparation over another; but, as it is convenient to become familiar with one, I have in my own practice, of late years, almost restricted myself to grey powder. I prescribe it usually in pill, in doses of from one to three grains three times a day, and often in combination with Dover's powder. It is only seldom that an unlooked-for salivation occurs, and it is equally rare to have any trouble with the bowels. Most of my patients continue throughout at their ordinary occupations. A strong reason for preferring to give pills, instead of using inunction or the bath, is, that it is often essential to avoid confinement to the house, and also to run no risk of attracting the attention of the family. Inunction, which is still in general use over the continent, and is without rival at Aix-la-Chapelle, is a more or less dirty method; can scarcely be concealed from servants; and further, with our English ointment, is very prone to irritate the skin and bring out eczema. As I do not believe that it has any real advantages to compensate for these drawbacks, I never resort to it. The vapor-bath, as proposed by Langston Parker and modified by Mr. Lee, I have the fullest faith in, and have seen excellent results from it in certain intractable cases. It is, however, troublesome, more or less expensive, cannot well be used secretly, and for all ordinary purposes, it is not in the least necessary.

The grey powder does all that could possibly be wished. I must add to this, that I am always particular to use mercury sedulously to the local manifestations of the disease. The chancre is to be soaked with black wash; and to the skin-eruption an ointment of the ammoniochloride is almost always applied. If the throat become sore, a gargle of black wash or of the bichloride is usually prescribed.

“With regard to the dose, it ought to be sufficient to produce decided effect on the disease. If it be given for an indurated chancre, the hardness ought to begin to diminish within a week. The quantity required in order to effect this will be found as every one knows, to vary very much in different individuals. A few patients will be met with who appear to resist mercury in a most extraordinary manner, in whom it neither destroys the syphilis nor affects the constitution. As a rough rule, I always expect to have to give more mercury to dark complexioned patients than to others.

“The correspondent asks ‘if some preparations are more adapted to certain stages of the disease, say primary or secondary.’ In reply, I do not know of any special adaptation of this kind, but find the one I have mentioned the most convenient in all. The bichloride, which at one time I used to give largely in the later forms of secondary disease, I now rarely prescribe, having become more and more convinced that it is the mercury which is wanted, and not any special preparation of it; and that what is to be aimed at is mainly to choose that form least likely to irritate.”

NEW TREATMENT OF CANCER.

Another treatment of cancer has been brought out by Dr. Hasse, of Berlin. An account of it is given in the *Medicinische Central Zeitung*, February 18. Dr. Hasse injects, with a hypodermic syringe, pure alcohol, to which one per cent. of ether is added, not into the new growth, but around its edges, thus obliterating, he claims, the vessels, especially lymphatics, which convey the infection, and causing the atrophy of the growth itself. The pain is rather severe, but is much reduced by ice bags, and lasts only about two hours. The injections are repeated every eight to fourteen days, and have no alarming reactions. He claims striking success in carcinoma of the mamma, and in cauliflower excrescence of the uterus, but has failed in epithelioma of the lip, which he attributes to the impossibility of obliterating by this means the large and closely adjacent coronary artery.

EXTERNAL TREATMENT OF VARICOSE VEINS.

If Dr. Linon, of Verviers, is right in his reports of his treatment of varicose veins, many who suffer from them will thank him for his discovery, as it saves them the pain and danger of an operation. He says, in the *Tribune Medicale*, that he was for years treated such cases with success by swathing the leg in a flannel compress wet with a solution of chloride

of iron in water, forty-five grains to the ounce, and then applying a roller flannel bandage over it firmly for twenty-four hours. This is to be repeated daily for a week or two weeks, when the patient is, or ought to be, well.

ERGOTIN INJECTIONS IN PROLAPSUS ANI.

The eminent surgeon, Von Langenbeck, of Berlin, announces that he has lately been treating prolapsus ani “with astonishing success” by hypodermic injections of a solution of ergotin (five to fifteen parts to one hundred of distilled water). He replaces the bowel, and inserting the point of the syringe about three centimetres in depth in the cellular tissue, throws in from one to two grains of ergotin. This should be repeated every three or four days for three or four weeks, any hard fecal masses in the bowels being first removed by a simple injection. As a means of treating a most obstinate and troublesome complaint, this method, sanctioned by so eminent a name, deserves careful repetition.

HOOPING COUGH.

Dr. Stephens, of Ilminster, gives his experience with various remedies in this disease, in the *British Medical Journal*, as follows:—

I must give the preference, in an ordinary case, to small doses of compound tincture of benzoin, frequently repeated. If the cough be more than usually spasmodic, I find dilute hydrocyanic acid, combined with bromide of potassium and camphor mixture, very serviceable; in the latter stage of the disease I much prefer alum, combined with dilute nitric acid and gentian, to any other astringent tonic; although in all cases everything depends upon the diathesis of the patient. I was greatly disappointed in the use of chloral hydrate, as in one case only could I detect the slightest benefit.

TREATMENT OF GRANULAR LIDS.

In a clinical lecture on this subject, in the *Irish Hospital Gazette*, Dr. Swanzy remarks that the first and most important thing is to provide abundance of fresh air, both within doors and without. The patients should never be allowed to remain moping in the house, as he is apt to do, but should be made to take several hours open-air exercise daily. More, he is convinced, may be done in many conjunctival diseases by fresh air alone than by any other treatment without it. It probably acts directly and locally on the conjunctiva, and not in any round about way through the constitution. When vascular reaction is insufficient for the absorption of the granulation, it should be excited; when excessive, it should be restrained. Hyperæmia may be excited by warm fomentations and by sulphate of copper. Excessive leucorrhœa may be checked by nitrate of silver solution, containing ten grains to the ounce, applied by means of a camel-hair brush to the com-

pletely averted upper lid. A little solution of common salt should be at hand to remove excess, and this again may be washed away with plain water. The effect can be modified by the length of time the solution of the nitrate is allowed to remain in contact with the membrane. When the leucorrhœa is only slightly in excess, the liq. plumbi subacet. dil. of the Pharmacopœia, without spirit is an admirable thing; it also should be washed off with plain water, and its use in this way is not contradicted by the presence of ulcers on the cornea. It is most important, in using any local application, to thoroughly evert the upper lid, in order that that part of the membrane may be reached which is reflected from the lid to the globe, for a neglect of this part may render the treatment abortive. Fresh cases of acute granular ophthalmia (military or Egyptian ophthalmia) do not require any topical application. Ice compresses alone may be placed on the lids, a leech or two at the inner canthus, and the patient should be purged.

URETHRAL FEVER FROM CATHETERISM—ITS NATURE AND TREATMENT.

BY J. W. S. GOULEY, M.D.,

SURGEON TO BELLEVUE HOSPITAL, NEW YORK.

When an instrument is introduced into the urethra, for the purpose of exploring the bladder, for drawing off the urine, or for dilating a stricture more or less grave, local and constitutional accidents sometimes supervene, and such casualties are most frequently the result of violence: but occasionally cautious, gentle, and successful catheterism is followed by alarming symptoms and even by death.

These constitutional manifestations are: 1st, Rigors with febrile reaction, sometimes followed by suppression of urine, and spoken of under the generic term of urethral or urinary fever.* 2d, Pyæmia.

It is a well-established fact that urinary or urethral fever arising from violence to the urethra or bladder is "due to shock propagated by the sympathetic nervous system and reacting upon the blood vascular system," and that there is some analogy between this ailment and malarial fever; hence the additional title of *intermittent* urethral fever. Urinary fever may be ushered in by a very slight rigor, or even only by a sense of formication or of horripilation, followed by little if any febrile reaction, or the attack may be of the most violent, overwhelming, fulminating character, similar to congestive remittent fever of the severest type, and may cause death in an extremely short space of time. Mr. Banks relates the case of a man between forty and fifty years of age, apparently much broken down in health, who was treated at the

* Urinary fevers occur very frequently in cases of urethral, prostatic, and vesical trouble, where no instruments have ever been passed, and is then an indication of the existence at least of renal congestion. But in these instances it is—with the exception of cases of far advanced disease—of a milder type than when it occurs from instrumentation, and is often mistaken for malarial fever. The removal of the cause of vesical trouble or of urethral obstruction soon cures this form of "ague."

Liverpool Royal Infirmary for urethral stricture. There was a false passage in the urethra, and the first catheterism failed, but the second was successful (No. 6 or 7 catheter), and though difficult "no undue violence was used and very little pain was complained of; there was no bleeding and nothing to indicate that there was any lesion of the urethra, except the pre-existing false passage, but almost immediately after the entrance of the catheter into the bladder the man was seized with a severe rigor. The instrument was at once cautiously withdrawn, but the patient passed into a state of profound syncope, and in a few minutes died." No autopsy could be obtained, but the existence of a flabby heart was strongly suspected.† Mr. Banks also gives the account of a typical case of urethral fever, from catheterism, proving fatal in six and a half hours after the passage of the instrument. In this case, the stricture, which was long and narrow and in the pendulous portion of the urethra, had been gradually dilated to No. 4. On the first day a small probe only could be passed, and was left in for half an hour. On the third or fourth day, Nos. 1 and 2 metallic bougies were tried but failed and a fine probe-pointed bougie was passed and left in ten minutes, and two minims of Fleming's tincture of aconite given. The dose of aconite was administered after each catheterism, which was practised every four days. On the next occasion Nos. $\frac{1}{2}$ and 1 were passed through the stricture, and after these a fine catgut bougie which was left in for an hour. When removed it was found still tightly grasped, and on this and each succeeding occasion a stream of urine followed the withdrawal of the instrument. In this way the urethra was dilated, chiefly by catgut bougies, till the fatal day, when No. 4 metallic bougie was passed through the stricture into the bladder for the first time. It went quite easily, was removed in about ten minutes, and was followed, as usual, by a stream of urine, but no blood came. The customary dose of aconite was given. In about half an hour he vomited his dinner, and soon had a rigor. In two hours he had another rigor, still continued to retch, and had a rapid pulse. Another two-minim dose of Fleming's tincture with brandy and water, but this was soon vomited, and nothing could be kept down afterwards. He then began to complain of pain in the region of the bladder and in the loins, the pulse became quicker and weaker, and in spite of all that could be done the retching continued, and he died, having lost consciousness but a moment before, in six and a half hours after the last catheterism. The autopsy revealed a long stricture commencing at about two inches from the meatus. No injury whatever had been done to the urethra. The organs were all perfectly healthy. No congestion of the lungs. In the bladder was about a teaspoonful of thick, muddy urine. The kidneys were examined

† "On certain rapidly Fatal Cases of Urethral Fever after Catheterism." By W. Mitchell Banks, F.R.C.S.E., Lecturer on Anatomy in the Liverpool School of Medicine. *Edinburgh Medical Journal*, June, 1871, p. 1174. The reader is referred to Mr. Banks' excellent article for some very important and interesting particulars regarding this subject.

with great care. They were slightly congested, and on pressure a thickish, turbid urine escaped from the calices, but beyond this no disease was found.

Similar cases were mentioned by Reybard, Velpeau, and others, but in most instances death has not been so sudden as in the foregoing cases of Mr. Banks; twelve to twenty-four hours, or even more, elapsing between the catheterism and the fatal issue. In cases of urinary obstruction with renal complication, unless the precautions to be hereafter indicated be taken, urethral fever is almost certain, at one time or another, to follow the introduction of the catheter. The instrument may have been passed at regular intervals for weeks or months without any very great amount of pain and without giving rise to any discomfort, or it may have been followed on one or two occasions by a mild attack of fever, but finally the same careful catheterism is practised—but on the *wrong day*, perhaps, when the patient's functions are temporarily disordered—and in a few hours he is suddenly and unexpectedly seized with a severe rigor from the effects of which he may never rally. Sir Henry Thompson reports a case in point at page 94 of his treatise on Stricture of the Urethra, third edition, London. He says, "I have seen one case of old standing and narrow stricture, in which death was thus caused within fifty-four hours of the passing of an instrument, the same that had been habitually employed on at least a hundred occasions before; no damage whatever having been inflicted by it upon the urethra, as verified by several careful observers on close post-mortem examination of the parts. Rigors and vomiting commenced about an hour after the catheterism, and not another ounce of urine was secreted from that time until death. The kidneys were congested to an extraordinary degree, and their substance was so soft and friable as to give way under gentle pressure. Very rapid changes had evidently taken place in these organs; but no signs whatever of inflammation existed in any other part of the urinary apparatus."

The grave type of urinary fever is a much dreaded, but now happily comparatively rare, accident of the operations of lithotripsy, lithotomy, internal and external urethrotomy and divulsion, as these operations are not resorted to, in our day, when advanced disease of the kidneys and of the bladder is suspected. In thirty-one operations of external perineal urethrotomy, there occurred but three cases of urethral fever, the attacks being mild in two, but fulfilling in one which ended fatally in fifty-six hours.

Between these two extreme types—the very mild and the very severe—there is a form of urethral fever preceded by headache, malaise, pain in the back, and, in fact, all the premonitory symptoms of an attack of ague, in which the chill may be deferred four, eight, twelve, twenty-four or even forty-eight hours after catheterism or other operation upon the urinary organs. This is, however, amenable to treatment, and recovery may be expected in the great majority of cases. It has long been supposed that the chill is ushered in by the passage of urine upon a denuded surface, but such is not the case, as the

rigor often occurs before the first act of micturition, or when—the patient having been repeatedly relieved by the catheter—not a drop of urine has come in contact with the urethral canal. If the contact of the urine with the raw surfaces were the sole, or even the principal cause of this trouble, urinary fever would almost always ensue from lithotomy, internal and external urethrotomy, and divulsion; but facts are against this theory.

Suppression of Urine is a common complication of urethral fever, but, though frequently fatal, is not necessarily always so. Mr. Banks, in speaking of the rapidly fatal forms of urethral fever with suppression of urine, says:—"In many cases no urine is secreted from the moment the instrument has been passed to the time of death, and this non-secretion has too often been reported as the primarily fatal cause, without consideration of the fact that it is simply a secondary effect upon the renal organs of the great general shock, and, although without doubt greatly tending to precipitate the fatal event, should by no means be regarded as a primary cause, but only as a complication. This is shown, 1st, by the fact that persons have been known to die soon after catheterism that the mere non-secretion of urine could have had nothing to do with the fatal issue 2nd, Even when no urine has been secreted, and time has been given for the non-eliminated urea to act noxiously, the symptoms have not been those of uræmic poisoning."

Among the severe cases that I have observed, several showed symptoms of uræmic poisoning: some have recovered, the majority have died, and the pathological lesions of the kidneys were, intense congestion in some, in others infraction, while in others still—that lingered several days—there was interstitial nephritis in its various stages, to suppuration. Suppression of urine may be partial or complete; the former is of frequent occurrence, while the latter is rare. The symptoms are, dull pains in the regions of the kidneys; no desire to void urine, some febrile reaction, thirst, sometimes vomiting of green bilious matter having a disagreeable urinous smell. The alvine dejections have the same urinous fetor, and the breath and the cutaneous perspiration are also offensively urinous.

Purulent infection occasionally follows urethral fever, although it usually occurs independently of this ailment; and the irregular chills which are caused by urethral pyæmia should not be confounded with those of urethral fever.

Treatment of Urethral Fever.—As the existence of renal disease is a strong predisposing cause of urethral fever, it is necessary, in case such disease is even suspected, to institute a preparatory course of treatment for several days before the intended catheterism be attempted; but I go further than this and prepare all patients—with the exception, of course, emergent cases—for five or six days before they are placed under mechanical treatment, and consequently now have, in my own practice, but very few cases of urethral fever to treat. The preparatory treatment which I usually resort to is as follows:—After free catharsis, rest should be

enjoined for a day or two, a hot hip bath ordered at night, a diluent drink three or four times daily, ten minims of tincture of chloride of iron three times a day, and five grains of quinine every night.

Quinine was first given in free doses for urethral fever by Bricheateau, who, in 1847, reported several cases successfully treated with doses of ten, twelve, and fifteen grains.* More recently, Ricord, who was not at first a believer in the efficacy of quinine in urinary fever, said, at the Surgical Society of Paris, that he had come to the point of never performing any operation upon the urethra without having previously administered quinine, and that ever since he had adopted this preventive treatment, the number of cases of urethral fever, so great before in his hospital service, had almost miraculously diminished. This alkaloid is doubtless one of the most effective of the remedial agents given to combat urethral fever, and should be administered in a dose of at least ten grains, with half a grain of opium after each catheterism, and, when necessary, should be increased to fifteen or twenty grains in the twenty-four hours.

Mr. Long speaks highly of two-minim doses of Fleming's tincture of aconite, for preventing rigors in cases where they had occurred after catheterism. † This is, I believe, another excellent remedy, but I would not take it in exchange for quinine. I have lately, however, given it in combination with quinine.

In the very mild cases of urethral fever, a hot drink of any kind, and rest for a few hours, will generally suffice.

When that ominous complication, suppression of urine, occurs, the case should be treated with the greatest caution; and, let me first say, the medical attendant should beware of administering stimulating diuretics. After the first catheterism—to positively exclude retention of urine—no instrument of any kind should be passed into the urethra. The next indication is to establish at once a vicarious excretion of the elements of the urine, if Nature in her conservative effort has not already done so. The skin and the intestinal mucous membrane should be made to do duty for the kidneys until the latter are in condition to perform their function. The *hot-air bath* is the most rapid mode of effecting diaphoresis, but as it cannot be given more than once or twice in the twenty-four hours, it is necessary to administer by mouth quarter of a grain doses of ipecac. every two or three hours, with hot borage tea, or any other diaphoretic.

Catharsis may be procured and kept up by any of the hydragogues; but small doses of sulphate of soda and of magnesia, in hot water, often repeated, will fulfil the object very well, without weakening the patient. Hop fomentations should be constantly applied during the day to the lumbar and hypogastric regions, and the loins should be freely dry-

cupped. Then a teaspoonful of the infusion of digitalis* should be given every hour or two hours, and the effect on the circulation closely watched.

The whole cutaneous surface, which exhibits sometimes such an offensively urinous odor, should be thoroughly dried and rubbed with a warm towel, at least three or four times in the day. The patient should be covered in bed, well nourished with concentrated mixed food, and, if he should become enfeebled by too profuse diaphoresis, a hot brandy toddy should be administered twice a day.

The patient is generally safe, if there be not advanced renal disease, as long as diaphoresis and catharsis can be kept up. Complete suppression of urine may last several days, but when the kidneys do not secrete urine in the course of three or four days, the chances of recovery are decidedly lessened.—*New York Medical Record.*

FETID CORYZA.

By J. SOLIS COHEN, M.D.

Lecturer on Laryngoscopy and Diseases of the Throat and Chest, in Jefferson Medical College.

The term *fetid coryza* appears to me better adapted than *ozana* to designate the condition under consideration, though merely indicating a combination of characteristic symptoms—*discharge and odor*—attending disease involving the nasal passages, without defining its nature.

Fetid coryza is produced by various affections. It may be due to ulceration of the mucous membrane of the nasal passages or of the sinuses communicating with them, whether erythematous, catarrhal, glandulous, scrofulous, syphilitic, lupoid, or cancerous. It may be due to destructive disease of the bones or cartilages of the nasal organs, or of their periosteum or perichondrium; whether the disease be idiopathic, traumatic, or specific. It may be due to the development of adventitious growths in the nasal structures themselves, or in others contiguous to them. It may be due to the deposition of calcareous matters from the secretions, and their aggregation into rhinoliths or nasal calculi. It may be due to the retention of some external foreign body, introduced by design or accident, and to the inflammatory processes resulting therefrom. It may be due to some unfortunate individual or family idiosyncrasy without any ulceration whatever, and even with little inflammation or none at all. It may be due simply to retention of nasal excreta and their decomposition *in situ*.

We have, therefore, to interrogate the part and the system in order to make a satisfactory diagnosis as to the cause of the discharge in any given case, and to form a judgment as to the proper method of treatment.

In order to examine the parts they must be washed out as thoroughly as possible by the use of

* Des Fièvres Intermittentes Pernicieuses chez les vieillards. *Archives Générales de Médecine*, 1847.

† *Liverpool, Medico-Chirurgical Journal*, January, 1858.

* The infusion should be used in preference to the tincture or the extract of digitalis, as it is known to be more effective as a diuretic than either of the latter.

the nasal douche, and syringes introduced anteriorly and posteriorly into the nasal passages; the best substance in general being tepid water impregnated with table-salt—a drachm to the pint. If this fails to detach the secretions, the phosphates of ammonia and soda or the carbonates of soda and potassa may prove more efficient in like proportion. Sometimes the forceps or the sponge-mop may be used to detach matters within their reach. In order to make a thorough examination of the parts, it is necessary that they be thoroughly cleansed. After the parts have been cleansed they can be examined before a strong light,—anteriorly by drawing the *alæ* aside so as to dilate the passage, or by introducing a speculum; and posteriorly with the rhinoscope. In this way we observe the appearance and condition of the mucous membrane, detect swelling, ulceration, retained secretions, foreign bodies, and morbid growths, exposed cartilage or bone, etc. The tortuous contour of the turbinated bones and nasal measures renders it impossible to examine these structures in their entire extent; but still, under a good light, they can be explored pretty thoroughly, especially with the aid of probes bent so as to admit of application to the surfaces of the various parts, on the same principle employed by the dentist in exploring the tortuous recesses in a carious tooth. Rhinoscopic inspection enables us to examine, in addition, the condition of the glandular tissue at the roof of the pharynx, a structure very frequently implicated in diseases giving rise to the discharge under consideration.

In some cases of fetid catarrh, the bones and cartilages of the nose, as far as their condition can be examined, appear healthy; and no ulceration of the mucous membrane can be detected on inspection anteriorly or posteriorly. There seems to be some constitutional idiosyncrasy in these cases, in consequence of which, retained portions of the nasal secretions undergo desiccation, and remain impacted in some portion of the sinuosities of the nasal passages; there undergoing decomposition. This condition of system has been compared to that which is attended by the peculiar, offensive smell of the cutaneous perspiration from the feet and armpits of certain individuals who cannot rid themselves of their unpleasant odor even by the most scrupulous ablution. In these idiosyncratic cases the discharge is by no means profuse, unless in exceptional instances. Sometimes, indeed, it is quite scanty; but it manifests a disposition to become desiccated into thin scales or crusts, removable only with more or less difficulty: sometimes by way of the nostrils anteriorly, and sometimes by a sort of inspiratory nasal sereatus, which, after repeated efforts, forces them through the posterior nasal outlets into the pharynx, whence they are expectorated. These crusts usually emit a horrible stench, perceptible at a distance of several feet, and capable of impregnating a large room with their fetor.

All that can be effectually accomplished in the way of treatment in these cases, seems to be the promotion and maintenance of an active condition of the secretory functions of the skin and kidneys by

frequent bathing and copious water-drinking,—keeping up a sort of sewerage, as it were,—and the thorough and efficient cleansing of the parts several times a day, especially at night and morning; making this act a constituent and essential part of the daily toilet, as much so as the use of the tooth-brush or the wash-basin. For this purpose the nasal douche of Thudichum, or some modification of it, is the best contrivance in most instances; but if the crusts are hard to remove, the use of the pharyngeal nasal syringe and of the continuous rubber hand-bellows syringe will afford better results; the latter especially in those cases in which crusts moulded to the contour of the posterior nasal outlet are apt to accumulate, and to dislodge which, readily, a stream of fluid entering with some force from the front is requisite. The ordinary solution of table-salt—a drachm or two to the pint of tepid water—fulfils the requirements of the douche for cleansing purposes; and detachment of the crusts is facilitated by the substitution or addition, as may prove most appropriate, of equal quantities of alkalines, such as the carbonate or bicarbonate of soda, phosphate of soda, and the like. At least a quart of the cleansing solution should course through the nasal tract at each night and morning ablution; part of it started through one nostril, and the remainder through the other. After the parts have been cleansed, the douche should again be used, containing a disinfectant in tepid solution. Permanganate of potassa, chlorinated soda, carbolic acid, and so on, employed in this manner, will, in great measure, control the fetid odor of the secretions.

Various local applications are made at times for the purpose of altering the nutrition of the mucous membrane, in the secretion of the glands of which the diseased action is supposed to reside. For this purpose various preparations of mercury and of iodine, the terebinthines, muriate of ammonia, etc., have been employed in the forms of ointment, powder, solution, and vapor; but, at least in the hands of the writer, they have proved of only questionable benefit.

Local cleansing, with disinfectant detergent douches immediately afterwards, and the maintenance of the cutaneous and urinary secretions by appropriate remedies, have rendered good service; but, to be efficient, resort to these measures must be constant.

Fortunately, in this variety of fetid coryza, the affection, whatever its real nature, moderates in severity as the patient becomes older, so that by the middle adult life it has subsided entirely, or in great measure. It is a long while to await permanent relief, to be sure, but it is better than no prospect of cure.

Another form of fetid coryza, attended with certain local manifestations to be described farther on is engrafted upon the strumous diathesis; and this variety, from its persistence, and from its ultimate destructive results,—which, when very extensive and insufficiently attended to, resemble so much the effects of analogous conditions in constitutional

syphilis,—seems to contribute some force to the doctrine that scrofula is but an inheritance of syphilis; modified, it is true, but bearing a relation to that virus similar to that which some authors trace between varicella and variola.

These cases usually originate in an acute coryza or catarrh, the result of exposure to cold. This catarrh gradually becomes chronic, the attendant discharge more or less profuse, varying in color and consistence, being at one time muco-purulent, at another purulent, sometimes sanguinolent, and so on. The odor of the discharge is exceedingly offensive, and there is a permanently unpleasant odor of the patient's breath, rendering propinquity to the individual very disagreeable.

In these cases crusts of inspissated mucus accumulate at the outlets of the posterior nares from detention there of the secretions, and they often become moulded to the form of the opening, presenting, when discharged, a peculiar honeycomb-like configuration. These moulds are usually several days concreting, and become discharged perhaps once or twice a week, sometimes oftener, sometimes less frequently. When discharged at long intervals, small, dense clumps of irregular conformation, and of similar constituents, will be occasionally drawn into the throat by forced nasal inspiration, and be then expectorated. These will possess the characteristic odor. Sometimes small caseous like concretions will be hawked down, apparently from the glandular tissue at the nasal portion of the roof of the pharynx, similar in appearance to the analogous matters sometimes discharged from the tonsils, and, like them, of an intolerable stench when crushed. In some instances, desiccated crusts can be seen upon the glandular masses at the roof of the pharynx, on pharyngo-rhinoscopic inspection. When examined immediately after spontaneous or artificial removal of the crusts, this glandular tissue is seen to be spongy, and, if the removal has been forcible, is most likely to bear decided evidence of hæmorrhage. Pain will be complained of in the parts and will be referred especially to the region of the frontal sinuses.

This form of disease of the nasal passages is met with in all classes of society: in the robust individual no less than in the delicate one; in those who have been tenderly reared, and in those who have been brought up in the roughest manner. It may make its appearance at any age, but seems to be most frequently noticed for the first time about the period of the second dentition. Most of the patients I have seen have been girls from six or eight years of age upwards to confirmed puberty or early adult life.

If, after thorough cleansing with the douche, syringe, or forceps, the parts are carefully examined,—anteriorly by the aid of hook, probe, dilator, or speculum, and posteriorly by the rhinoscopic mirror,—some points of ulceration, superficial or deep-seated, will usually be detected upon the mucous membrane. These ulcerated spots may occupy the free surface of the turbinated bones, or the lower region of the septum and even when ulceration can-

not be discovered in these situations it is often fair to infer that it is likely to exist upon some portions of the turbinated bones altogether out of the field of direct or indirect vision. The nasal mucous membrane will be swollen, often to such a degree as to occlude the passage at one or more points; in some instances the result of sero-fibrinous or fibrinous infiltration into the submucous connective tissue, in others, the result, in addition, of actual hypertrophy of this tissue. In some cases little bags of thickened tissue or exuberant folds project from the walls and are sometimes mistaken for neoplasms. The parts are usually very much congested, though they do not bleed as a rule, except upon rough manipulation; and they are very sensitive to contact with the probe in some instances, and not at all so in others. The mucous membrane of the posterior portion of the septum is often seen by the rhinoscope, pushed off from its sides by submucous infiltration, bulging into the free space of the nasal outlets so as to present much the appearance of turbid morbid growths.

As a matter of course, in this condition, the patient will experience more or less difficulty of nasal respiration; one nostril or the other, in many instances, being impervious to air, nearly all the time. This induces a habit of keeping the teeth slightly apart to facilitate breathing, and favors the formation of chronic pharyngitis; a condition which is often coincident to all the affections under consideration.

If the disease has existed for a number of years—and it is essentially chronic—the ulcerations will have extended beyond the limits of the tissue proper of the mucous membrane, and will have involved the cartilages and the bones, portions of which will sometimes have been destroyed, and have been discharged spontaneously; so that the cartilaginous septum is in many instances found to have been pierced through, sometimes in one or two small perforations, but more frequently in a single large, irregular hole, perhaps admitting the end of the little finger, or the end of a larger one, and looking as if it had been gouged out with some rude tool. In some instances, one or more of the turbinated bones, usually the middle one, will be necrosed and bare in its entire extent, or the greater portion of it, awaiting its extraction,—an operation readily accomplished with polyp-forceps. Sometimes it has been removed spontaneously, or has been pulled out by the patient, leaving a large, free space in the nostril, through which the posterior wall of the pharynx can be seen, or a portion of the upper surface of the velum. In some instances the destructive inflammation will have progressed to a farther extent, and have involved portions of the superior maxillary bone, from which copious accumulations of fetid pus and necrotic particles will have been discharged at intervals. Cases of this kind will have produced some alteration in the external configuration of the parts, the nose being sunk in or flattened out, and the nostrils distended. In some instances the orifices of one or more sinuses will be recognized, the tracks of which cannot be

readily traced, perhaps because they course around the scroll of the turbinated bone. From these openings, on pressure behind them with a probe, a few drops of creamy pus can often be discharged.

Some other evidence of the strumous diathesis is usually apparent.

In cases of undoubted syphilitic origin,—and the distinction between serofulous and syphilitic coryza is not always well marked,—the involvement of bony structures will progress to a much greater extent than has already been described, the earlier manifestations having been similar to those of catarrhal and serofulous inflammation, but more active. The turbinated bones, the vomer, the nasal bones, the palate bones, the lachrymal bones, the sphenoid, and the ethmoid, will often undergo more or less destruction. In some instances pharyngeal rhinoscopy and the use of the probe will early reveal necrosis of the vomer, the sphenoid, and the basilar process of the occipital bone. The discharge in these cases is not, as a rule, so offensive in odor as in the serofulous cases; but it is equally persistent, and will continue as long as any dead bone remains undischarged. The tortuous contour of the nasal passages and the sinuses leading to them is such as to render it impossible in many instances to remove all of this dead bone by surgical interference through the nostrils anteriorly or posteriorly so that its discharge must be awaited bit by bit. The amount of destruction that the parts may undergo under such circumstances is enormous. In some instances the cranial vault has been pierced, and the resulting meningitis has put an end to the complaint and to the patient.

The amount of the discharge, its consistence, and the intensity of its disagreeable odor, will vary during the course of a fetid coryza, whatever may have been its origin. An inflammation of the parts such as follows a cold, a determination of blood to the head, over worked, the approach of the menstrual flux, all seem to increase the offensiveness of the discharge. This will become moderate after cleansing with the douche, and the application of remedies; but will wax just as bad as ever in a few hours, or a few days. When there is an involvement of bone, or a fresh involvement of bone, the fetor will be increased until the necrosed portion has become exfoliated and discharged.

The patient is usually cognizant of his extremely unpleasant condition to a certain extent, but is unaware of the full amount of stench emitted from his body, because the sense of smell is obtunded, and in some instances entirely destroyed. With the loss of smell there is, in consequence, more or less loss of the sense of taste; so much of it as is dependent on the sense of smell. In those cases in which the frontal and maxillary sinuses are effected to a greater extent than the nasal passages, the patient is better able to appreciate his infirmity, for the sense of smell is still conserved to a considerable degree. The offensiveness of the odor in extreme cases is beyond description, and must be felt to be comprehended. It will impregnate a room for hours,

and deter the practitioner from persisting in proper efforts to relieve the local condition.

TREATMENT.

The treatment of a case of fetid coryza will depend upon its nature. When due to the presence of a foreign body, a rhinolith, or a morbid growth, the removal of the exciting cause will cure the discharge. In cases with constitutional taint, systemic treatment is required. The treatment of this condition, in fact, is simpler in principle than in practice; but it is always tedious, and often unsatisfactory. Palliation of the severer symptoms and diminution of the fetor can almost always be effected, but a thorough cure often requires months of persistent treatment; in some instances seeming almost unattainable, and in others, quite so. When the larger bones are diseased, and it is impossible to get access to them, the condition will continue for years; dead bone being exfoliated splinter by splinter, and fresh involvements becoming new sources of evil as older ones are undergoing amelioration.

In serofulous cases we can endeavor to improve the tone of the constitution by resort to systemic remedies, such as cod-liver oil, quinine, and iron, the preparations of iodine, arsenic, and so on; and we may thus repress increase in the malady, even if we fail in restraining it. The administration of cubebs, preferably, in my own practice, in doses of from fifteen to twenty drops, or more, of the oleoresin on sugar, after meals, will sometimes diminish the copiousness of the secretions to a certain extent, and modify their character by the local influence of the drug in its elimination through the mucous membrane of the nasal tract.

The decidedly syphilitic cases, when not so far advanced as to be irremediable, are much more manageable under systemic medication than are the idiopathic and serofulous cases. Here small doses of the bichloride of mercury, with the free use of the iodide of potassium, are just as serviceable as in other forms of constitutional syphilis, especially if the general vigor of the patient has not been greatly impaired. If the general health is poor, a generous allowance of nutritious diet, assisted by a tonic course of treatment, will be necessary before beneficial results can be expected from specific remedies.

All forms of fetid coryza require local treatment. The parts should be frequently cleansed, and topical remedies assiduously applied. Without preliminary cleansing, local remedies are of little avail: they become entangled with the secretions to a certain extent, and cannot exert that good effect upon the parts which they exercise when applied upon a clean surface.

As mentioned in connection with cleansing the parts preparatory to examination, we use for this purpose the nasal syringe, applied anteriorly and posteriorly, and the continuous nasal douche; employing the medicinal articles already enumerated. These ablutions are by no means to be neglected, but should be attended to as punctually and as scrupulously as the patient attends to other wants of nature.

The local applications for remedial purposes consist of solutions, powders, vapors, and unguents, brought in contact with the parts by suitable appliances. When ulcerated surfaces can be reached by instruments introduced within the nostrils or behind the palate, they should be regularly touched by the sponge, cotton wad, or hair pencil, loaded with a solution of nitrate of silver, sulphate of copper or of zinc, carbolic acid, chromic, nitric, or muriatic acid, or the acid nitrate of mercury, as the case may seem to demand. Dead bone, where accessible, should be removed by the forceps, assisted, if need be, by the knife or scissors. Too much force should not be exerted in the endeavor to remove dead bone. It is better practice often to use frequent traction from side to side with forceps, in a sort of dislodging motion, so as to loosen the pieces of dead bone, and thus gradually render them sufficiently movable to be extracted without much physical effort. If the bone is too large for removal through the nostril in mass, it may be crushed between the blades of strong forceps, or divided by cutting-pliers, and be extracted piecemeal. In many instances the dead bone may be removed through the mouth by means of curved forceps passed up behind the palate.

The contact of the opposing surfaces of mucous membrane can often be overcome by the daily interposition, for an hour or more at a time, of strips of compressed sponge, or of tubes of laminaria; mechanical appliances which compress the parts as they may imbibe moisture from the secretions, thereby favoring absorption of the products of submucous infiltration. Where hypertrophied or exuberant mucous membrane exists, and where internal compression is insufficient to enlarge the passage for the free ingress and egress of air and the free discharge of the secretions, it is good practice to twist off portions of the membrane with delicate forceps, so that cicatrization of the irregular edges of the wound may enlarge the passage. The free bleeding accompanying this procedure exerts a salutary influence upon the parts; and though the operation is very painful, it is so efficient in its relief that the patient will readily submit to it again and again, for the sake of the ease it affords in respiration afterwards.

The solutions used by douche or injection may contain chlorate of potassa, alum, creasote, or carbolic acid, permanganate of potassa, chloride of lime, or similar substances, which, in addition to their local action on the parts, tend to control fetor. Or we may use special injections or sprays of nitrate of silver, sulphate of zinc and of copper, the sulpho-carbolates of zinc or lime, bichloride or iodide of mercury, chloride of zinc, chloride of lime, and the like. These injections should be employed at least twice a day, night and morning, and, where practicable, three and even four times a day; and they should always be preceded by the use of the douche for cleansing-purposes. They should be used in weak dilution at first,—say two or three grains to the ounce,—and be gradually increased in strength as tolerance of them is manifested; care being taken

that none of the solution is swallowed by the patient, on the one hand, and that too free use of remedies which act promptly on the system be not made, on the other; for the nasal mucous membrane readily absorbs certain remedies, and the proximity of the olfactory filaments to the nervous centre favors the systemic effect of others. This latter fact is often utilized to subdue the pain in the frontal region, by the local application of an ointment containing three or four grains of morphia, or one or two of the extract of stramonium, to the ounce; not more than the volume of a pea being used at a time.

A solution of the chloride of lime was used in this city, with great success, by Prof. Horner, who injected each nostril twice a day with a solution containing a teaspoonful of the chloride of lime in a wineglassful of water. This practice is not much in use to-day, but it deserves to be. A somewhat similar formula, from which I have sometimes obtained very satisfactory results, contains from thirty to sixty grains of the chloride of lime to the ounce of the decoction of krameria; of which two or three drachms, or more, diluted with an equal quantity of water, are injected into the nostrils night and morning, immediately after the use of the douche. Sometimes the parts will not bear a solution of this strength, and it must be diluted accordingly. When the remedy excoriates the external tissues, as it will do sometimes, its use must be suspended or its strength reduced, as may seem most judicious. Perhaps a preliminary coating with colodion will prevent this excoriation, but I have never tried it.

Glycerin is sometimes of great service as an injection, particularly in scrofulous cases. Being bland and unirritating, its affinity for moisture of all kinds facilitates the separation and removal of the secretions, inspissated crusts, and detached fragments of dead bone. The addition of iodine, in the proportion of a grain or two to the ounce of glycerine, is sometimes advantageous.

Prof. Trousseau relied greatly upon certain medicated powders to be snuffed up by the patient twice or thrice a day, after having cleansed the nostrils as thoroughly as possible. His principal formulæ were calomel, a drachm to the ounce of sugar, and red precipitate, forty grains to the ounce of sugar; their use being regulated in accordance with the irritation produced. Another favorite powder, with which he was very successful, was composed of bismuth rubbed up with equal parts of Venetian talc, and this, on account of its innocuousness, was used as freely as was desired.

Camphor, tannin, cubebs, and other substances, separately or in combination, have been used in a similar manner; some practitioners mixing them with two or three times their bulk of Scotch or Welsh snuff. Various mechanical appliances are in use for the purpose of injecting the powders upon the parts.

Citrine and other ointments, more or less diluted, are sometimes used locally after thorough cleansing; being applied to the parts by the little finger, a hair pencil, or a cotton wad on the end of a wire.

The principal remedies used in the form of vapor are preparations of mercury, evaporated over a spirit-lamp, the fumes from which are drawn by inspiratory effort through the nostrils. The fumes of muriate of ammonia from the heated salt itself, or in a nascent state from commingling of the vapors of muriatic acid and strong aqua ammoniæ, are also used a great deal in the scrofulous cases, both for local and constitutional effects.

With all these resources at command, we are able to improve the condition of patients affected with fetid coryza, and place them under the most favorable conditions for the cure of whatever affection has given origin to this loathsome catarrh.—*Philadelphia Medical Times.*

CLINICAL LECTURE.

ON SEBORRHOEA CAPITIS.

BY LOUIS A. DUHRING M.D.,

Clinical Lecture upon Diseases of the Skin in the University of Pennsylvania, and Physician to the Dispensary for Skin Diseases, Philadelphia.

Reported by DR. ARTHUR VAN HARLINGEN.

The patient, whose case forms the subject of our study to-day, complains of an affection, not indeed severe, and certainly not dangerous, but yet one of such character as to claim close study of its features and careful treatment, if we would succeed in its cure.

He is, you observe, a man of middle age, pale, and evidently out of health. A weaver by occupation, he is confined much of the time to a dark, unwholesome apartment; his hygienic surroundings in fact, are bad.

The disease for which he seeks relief we find to be localized in the scalp, showing itself on the surface in the form of a copious accumulation of small, pearly-white, greasy-looking scales.

The production of these scales is attended with considerable itching, and is so rapid that, although the scalp may be thoroughly cleansed in the evening, yet by the next morning, they are present again as abundantly as ever.

The duration of the affection is about three months, or rather about that length of time has elapsed since the itching and scaliness first became so annoying as to attract the patient's attention. It is probable that its origin may be referred to much earlier date.

These facts in the history of the case having been ascertained, let us examine the appearances presented, and determine, so far as we may, its exact nature.

Have we any extraneous causes of irritation, such as might produce a condition like the present?

As to stimulant applications, our patient informs us that none have been made; but as to pediculi, the only other likely source of external irritation, some examination will be necessary.

The diagnosis of phtheiriæsis is not difficult, since either the unmistakable pediculus is present *in propria personâ*, or its representative ova, known by the following characteristics, may be discovered.

The ovum of the *P. capitis* is a small, pear-shaped,

grayish-white body, about the size of a grain of sand, and is found attached quite firmly by its smaller end, to the hair, at a considerable distance from its insertion into the skin. Examination of our patient's scalp shows the absence of living pediculi; but are these grayish particles sticking to the hairs, at various points, ova? At first glance, they certainly appear to be such; but on closer inspection they are seen to have an irregular shape, to be easily brushed off from the hair, and in fact, to be in all respects identical with the scales on the surface of the scalp.

Phtheiriæsis, then, the only remaining source of irritation, being excluded, let us proceed to an examination of the eruption itself, with the object of ascertaining which, among several affections likely to be found in this locality, we have in the present case.

There are only three diseases occurring on the scalp in a form resembling the one before us: they are *psoriasis*, *eczema*, and *seborrhœa*. It would be impossible to give such a verbal description of these affections as would enable you always, and under all circumstances, to recognize and distinguish them; experience alone will enable you to do that. Their leading characteristics, however, you should certainly be acquainted with. They are as follows:

Psoriasis capitis manifests itself in the form of dry, white scales, scattered thorough the scalp. It usually extends a little beyond the space covered by long hair, so as frequently to form over the forehead, ears, and neck, a whitish or reddish border encircling the scalp. It is not apt, as a rule, to itch so intensely as the other two affections under consideration, and when occurring in the head is almost invariably found in other parts of the body, especially around the elbow and knee-joints.

Eczema capitis may occur either in the vesicular or squamous form. If it occurs in the former, the peculiar structure of the scalp modifies, to some extent, the appearance of the disease.

In mild cases, this variety presents itself in the form of yellowish, friable crusts, consisting of epithelial scales mingled with dried serum. On raising these crusts, the surface beneath is found to be red, shining, and moist. In severe or neglected cases the secretion of the sebaceous glands mingles with that of the vesicles, and the product of disease, becoming decomposed, give rise to a peculiar and disgusting odor. The hairs, also, become matted together, and the most severe form of the affection is called in some countries "*plica polonica*," a mixture, in fact, of *eczema*, *seborrhœa*, and filth.

In the squamous form of *eczema*, the scalp is red, and covered with fine, dry, white scales.

Seborrhœa capitis is characterized by the abundant production of scales in the same manner as the two diseases just spoken of, but these scales are seen, on careful inspection, to possess quite a different character from those of *psoriasis* or *eczema*. They are numerous, pearly-white, and have a decidedly greasy lustre and feel. They have also a certain cohesiveness, which causes them to accumulate in masses, but they have no tendency to produce matting of the hair.

On raising a patch of seborrhœa, we find the underlying skin red indeed, and somewhat chining but with no appearance of moisture, as with eczema.

A careful examination of the patient before us will justify the assertion that we have here a well-marked case of the last of these three disease,—seborrhœa capitis,—seborrhœa of the head.

There are two varieties of seborrhœa: seborrhœa oleosa and seborrhœa sicca. The former is characterized, as its name would indicate, by increased fluidity of the sebaceous secretion, which is also poured out in such quantity that the affected skin frequently looks as if it had been freshly anointed with oil. This variety is most usually found on the face, although it sometimes occurs on the scalp and elsewhere. When persons who are exposed to dust or dirt become subjects of this variety of the disease, the visage presents a peculiar and constant grimy appearance, which nothing but frequent cleansing can prevent.

In seborrhœa sicca, on the contrary, the more solid constituents of the sebum predominate and the secretion assumes an inspissated condition; hence the name, dry seborrhœa. It is the latter variety of seborrhœa which we have in the case before us.

This affection is not invariably confined to the scalp; on the contrary, we frequently see it on the face, and, in fact, it may occur in any part of the body where there are sebaceous glands. It is decidedly more common, however, in the scalp, since in this locality the sebaceous glands are more numerous and active than elsewhere.

When seborrhœa sicca occurs in non-hairy portions of the body, its appearance is decidedly modified; fewer scales are detached, and the diseased surface usually presents simply a circumscribed patch of congested skin, with slightly roughened cuticle.

The pathology of the affection is as follows; When from any cause the sebaceous glands take on abnormal action, not only is their secretion altered, in one way or another, and poured out in increased quantity, but their epithelial investment itself becomes to a certain degree affected, and the lining cells are reproduced and thrown off with unhealthy rapidity. It is the cells constituting this lining membrane, as well as the inspissated sebum which mats them together, which go to form the pearly-gray scales observed on the surface of the skin.

The name of the disease—seborrhœa—is derived from the Greek, and signifies a flow of sebum to an abnormal amount, this being the characteristic feature of the affection.

The rapidity with which the scales are thrown off is astonishing. Our patient has just told us that in a short time the scalp may become entirely covered with them. This rapid proliferation of the lining epithelium with abnormal and excessive secretion from the sebaceous follicles may go on for years if unchecked, and finally the disease may involve the hairs—their sheaths themselves, and cause the death of the hair. Seborrhœa becomes, in this way one of the most frequent causes of premature baldness.

The origin of the affection is usually to be found in some defect of nutrition, such as chlorosis or

anæmia in both males and females. In the latter, irregularity in the performance of the menstrual function is a frequent cause. In fine, all those conditions of want of health which are indicated by cold hands and feet, as well as various forms of indigestion, may be indicated as among the known causes of seborrhœa.

Our patient is evidently anæmic, and badly nourished, and our treatment of his skin-trouble will be based upon the removal of this condition. So far as he is able to follow our advice, he will take fresh air and exercise. His food shall be nutritious, with strict avoidance of pastry, fat meats, or any form of diet which may be found to cause indigestion.

As regards medicinal treatment, he will be ordered *ol. morrhœæ*; a tablespoonful of the oil to be taken about an hour after ordinary meals. If this does not derange the stomach or digestive apparatus, he will be directed to continue its use for several months, intermitting it for a short period perhaps at intervals. The cod-liver oil is often of decided benefit in these cases, and may be relied upon as a valuable auxiliary. But the medicine, which is of paramount importance and of unquestionable service in the majority of cases of seborrhœa, is iron; it is indicated and will be of service in the case of the patient before us. He will be ordered four grains of the tartrate of iron and potassium in sweetened water, to be taken thrice daily, directly after eating. The use of this preparation will be persevered in for some time; several months at least.

We shall scarcely look for much improvement before a month's time. Seborrhœa is slow to get well; it is a disease which has to be treated with care and discretion, requiring time to undergo change. Until a certain alteration has been produced in the constitution of the patient, it is useless to expect a cessation of the process; for the disease, in the case under consideration, is no mere local trouble, but a state emphatically associated with his general poor health and improper condition. Relying upon the oil and iron for the internal treatment, together with hygienic measures, it will be necessary at the same time to employ local treatment as auxiliary means of relief. It is important to keep the scalp thoroughly clean and free from the products of the disease. To get rid of the scales we shall order him some alkaline liquid preparation. A very suitable wash for these cases is the *tinct. sap. viridis*,—a solution of *sapo viridis* in alcohol in the proportion of two ounces of soap to one of alcohol. This is a valuable and efficacious alkaline wash for various conditions of the scalp, and is of particular service in seborrhœa capitis. It is to be rubbed upon the head by means of a piece of flannel, adding a sufficient quantity of water to the scalp from time to time, to make an abundant lather. This is thoroughly rubbed into the affected parts, and after ten or fifteen minutes completely washed out of the hair by means of an abundant supply of warm water, care being taken to rid the scalp entirely of suds. The scales will, by this means, be completely removed. The hair and scalp should now be dried with a soft towel until all moisture has disappeared. Some oily or fatty pre-

paration is now to be applied directly to the scalp, and to the hair as well, in order to counteract the effect of the alkaline wash, which tends to produce shrinkage of the skin. We shall order for our patient an oil composed of one part glycerine, one part ol. ricini, and two parts alcohol, to be worked into the scalp after each washing with the soap preparation.

There are cases of seborrhœa, however, where the products of disease have been allowed to accumulate to such an extent that they form quite a crust. In such cases a quantity of olive oil—say a teacupful—should be well worked into the scalp, and the head covered with a night-cap. If this is done at night, the crusts and scales will have become so far softened by the next morning that the wash above mentioned may be successfully used.

Finally, you should remember that in such cases as these of old standing, and where the disease has made much progress, many hairs will have become loosened from their sheaths, and will remain attached to the crusts only. Of course, the first time the patient's head is thoroughly cleansed all these detached hairs come away, and the effect at times is somewhat startling. It should always be ascertained if many hairs have become loosened or entirely separated before the cleansing process has been commenced, that the patient may be warned of the probable result.—*Philadelphia Medical Times.*

SULPHUR IN THE TREATMENT ACNE.

Dr. Sidney Ringer says (*The Lancet*, Feb. 21) : "The topical effects of sulphur ointment, or, of an iodide of the hypochlorite of sulphur, or, still better, of the iodide of sulphur of the Pharmacopœia, is most marked an *acne indurata* and *acne rosacea*, these effects being twofold, and even opposite, according to the stage of the eruption. If applied at the very commencement of the eruption, as soon as the little hard knot is felt under the skin, further development is arrested, and the hardness speedily disappears. For instance, if smeared over the hardness just before going to bed, in the morning scarcely any induration will be felt, though after a time, perhaps, from exercise or the irritation from washing, much of the hardness may return, to be again removed by a new application of the ointment, so that in two or three days a papule that threatened to become of considerable size may be completely dispersed.

When, however, the nodule has advanced further, and suppuration has set in, then the effects of the ointment are much like those of the sulphides, administered internally, on boils, hastening maturation, limiting the swelling and hardness, and thus considerably curtailing the duration of the eruption. Nay, further, if rubbed over the skin, it appears to check the formation of acne spots. If rubbed over the nose and neighboring parts of the face in *acne rosacea* its effects are often most striking. Not only does it act as an *acne indurata*, but the hardened, swollen tissues become softened and reduced to a more natural state. He has found the iodide of

sulphur likewise useful in bromic acne, reducing the eruption, or at least considerably reducing the size of each spot. In acne the ointment should be thinly spread over the eruption, night and morning.

ON SULPHIDE OF POTASSIUM, SULPHIDE OF SODIUM, SULPHIDE OF CALCIUM.

Dr. Sidney Ringer speaks enthusiastically of the influence of these remedies upon the suppurative processes, such as abscesses, boils, and scrofulous sores. When sulphide of calcium or potassium is administered, a thin, watery, unhealthy discharge becomes at first more abundant, afterwards diminishing, and throughout continues thicker and healthier, possessing, indeed, the characters of "laudable" pus. The condition of the sore improves correspondingly and its healing is promoted. The sulphides appear, often, to arrest suppuration; serving to reduce inflammation, and avert the formation of pus.

The effects of these remedies are equally conspicuous in mammary abscesses, although in rare instances they appear temporarily to increase the pain—a remark which seems, sometimes, to hold good with respects to boils. But, as a rule, the pain is speedily mitigated. Singular to say, he has found these remedies of much less use in forwarding the maturation and expulsion of pus in indolent tumors. For the relief of boils and carbuncles, the tenth of a grain of sulphide of calcium, given every two hours, generally prevents the formation of fresh boils, while it lessens the inflammation and reduces the area of existing boils, and quickly liquefies the "core," so that its separation is much more speedy than usual. In some cases of deep-seated boils and abscesses they are powerless.

A very beneficial effect appears to be exercised upon suppurating scrofulous glands in the neck. Here again they hasten the elimination of the pus, and subsequently the cheesy, scrofulous matter.

DIVISION OF THE SPINAL CHORD IN THE NECK.

Indian Medical Gazette, September 1, 1873.

N. B. Baillie records the case of a woman who lived for six hours after receiving a blow with a hatchet which cut through the third spinous process and the back part of the fourth cervical vertebra, dividing the spinal chord completely, and penetrating into the body of the vertebra in front of the spinal canal.—*Phil. Med. Times.*

INCONTINENCE OF URINE.

Dr. Thomas Kennard, of New York, uses the following ointment in the treatment of this disease:—Sulphate of atropia, ten grains; veratria, ten grains, hog's lard, twelve drachms. By rubbing the perineum three times daily with the ointment, in three cases of paralysis accompanied by incontinence of urine, Dr. Kennard obtained a complete recovery at the end of a few days.

MANIPULATION IN THE TREATMENT OF SPRAINS.

(*New York Medical Journal*, January, 1874).—
Dr. William R. Fisher reports the following interesting case:

A young woman fell from the top of a step-ladder and severely sprained her right ankle. The local application of ice and other antiphlogistic treatment enabled her at the end of ten days to make a short journey to her home. This was, however, followed by increased pain, swelling, and inflammation, which were again subdued by rest and cold dressings. During the next three months her foot improved slightly under the use of stimulating liniments; but by another fall she lost what little had been gained since the first accident. Iodine and frictions with camphorated oil reduced the pain and swelling and increased the motion at the ankle-joint, but this articulation remained weak and painful whenever use was attempted, and a point just below the external malleolus was exquisitely sensitive to pressure or upon motion. Five months after the original accident she entered a hospital; absolute rest in bed was enforced for two months, but when she got up her foot and ankle proved to be as useless as before, and her general health was decidedly impaired.

Galvanization, repeated blisters, and uniform pressure with wet sponges, as well as quinine, iron, and similar remedies, were all unproductive of any permanent good; and finally it was resolved to submit her to the treatment by manipulation. At this time she could walk a little upon crutches, using her left foot alone to receive her weight; there was an œdematous puffiness about the right ankle almost obliterating the malleoli; the foot had a bluish, dusky hue throughout, arising from a want of active circulation; the temperature of the right leg and foot was lower than that of the left. Pressure over the instep caused a soreness, along the skin below the external malleolus a sharp, darting pain. Passive movement at the ankle in the direction of flexion or extension, and especially lateral motion inward, excited the same sharp pain. Voluntary movement was confined to the toes, and even there, required considerable effort for its performance.

The repeated attacks of acute inflammation in this case had probably been the cause of its long duration, and had resulted in the formation of an unusually large amount of plastic exudation and fibrinous adhesions. The indications all pointed to the sluggish circulation in the ankle and foot as the chief obstacle to improvement.

Treatment was commenced by a general kneading and shampooing of the limbs and body until the patient had become used to the process, but after a few days the manipulations were performed as follows: The whole limb from the knee down was first rubbed and kneaded for twenty minutes lightly where the parts were tender, forcibly where the pressure was well borne. The skin was sponged with water and dried with a towel whenever the epidermis became dry and heated by the friction. The toes were passively exercised in various directions, and the ankle-joint was flexed and extended; the extent of move-

ment being governed by the amount of pain it produced. These manoeuvres occupied about five minutes, and were followed by the kneading and frictions a little more forcibly administered, which in turn gave way to the passive movements until the whole had continued for an hour and twenty minutes. At its termination there was a decided increase of motion and diminution of pain. This was repeated daily, the movements of the joint being gradually increased in force and length of the application, while the kneading and frictions were lessened.

On the seventh day of treatment, passive motion of the joints was in every direction and entirely painless; the adhesions had all given way as the force of the manipulations had been increased, snapping audibly one after the other; the foot was warm, there was no puffiness, and she was able to wear the same-sized shoe on the right as on the left foot. After twenty-one days of treatment, she gave up crutches altogether, and four days later she went to the seashore. Since then her progress has been steady, and she is practically cured.

Dr. Fisher believes that of all the means which are recommended for the treatment of sprains, manipulation is the simplest, the easiest in application, and the most efficacious. Quoting from M. Bizet, he says, "The cure by manipulation is the more prompt and certain in proportion as the remedy follows upon the accident, and it may be wrought both in simple and in complicated sprains, except in the case of fracture of the articular extremities."

EXPECTORANT MIXTURE.

The *Medical Record* states that an expectorant mixture much used in the New York Charity Hospital in cases of chronic bronchitis, and with very good results, is the following:—

Ammon. muriat.	
Liq. morph. sulph. (Mag.) aa	ʒi.
Syr. tolu.	
Syr. scillæ co., aa	ʒi M.
S. ʒi. ter in die.	

LINIMENT FOR ACUTE ARTICULAR RHEUMATISM.

The following is used in the same institution, as an application for the joints in this form of rheumatism:—

Tr. opii	ʒi.
Spts. chloroform	ʒi. iss.
Lin. saponis, ad.	Oi. M.

This liniment is applied freely over the joints, and immediately covered with cotton and oil-silk. The relief from pain afforded by this application has been very gratifying to all the rheumatic patients. The general treatment is alkaline.

THE CANADA MEDICAL RECORD

S. Monthly Journal of Medicine and Surgery.

EDITOR:

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MONTREAL, MAY, 1874.

MONTREAL GENERAL HOSPITAL.

At the annual meeting of the Governors of this excellent Charity, held on Thursday, the 22nd of May, the resignations of Dr. Scott, who has served the institution for some twenty-seven years, and of Dr. R. Palmer Howard, who has served about twenty-four years, in the capacity of attending physicians were received, accepted, and a cordial vote passed, conveying to them the thanks of the Governors for the faithful and zealous manner in which they had performed their duties. Although it is now becoming an established usage, that appointments to Hospitals should not be tenaciously held for a life time, yet we are sure that not a few who read the *Record*, will hear of the resignation of both these gentlemen with something like a pang of regret. For a quarter of a century they have faithfully and earnestly performed a noble work, many hundreds of medical students having, during that time, received instruction from them in the wards of the hospital. More especially will Dr. Howard be missed by the large number of students who each winter seek Montreal to benefit by the practice this hospital affords. His term of attendance was at this period, and the large class which invariably followed him around the wards, was the natural result of his ability as a clinical teacher. For this particular department he was pre-eminently fitted—rapid in diagnosis and able to impart in a fluent and ready manner, every point of interest and importance. To be gifted in this manner, is not a talent bestowed upon many. In the interest, therefore, of the profession, we feel that it is cause for regret, that Dr. Howard, when compelled by the pressure of practice to re-arrange his duties, was not transferred by the school, with which he is connected, to that department of medical teaching, which is admittedly difficult to fill, and for which he has shown most wonderful adaptedness. Clinical chairs in Montreal have, certainly of late years, been regarded as junior chairs. This we have always considered a great mistake, and if Montreal intends to remain the chief centre of medical educa-

tion for the Dominion, in this, as in some other matters, there must needs be some alteration.

TO OUR SUBSCRIBERS.

As the volume is drawing to a close, our subscribers will confer a favor by remitting *at once* the amount of their subscription.

WESTERN HOSPITAL OF MONTREAL.

This new hospital has organized under its act of incorporation, and has elected the following officers for the year 1874-5. Major Hiram Mills, president; William Workman, Esq., first vice-president; Hugh McLennan, Esq., second vice-president; Henry Judah, Esq., treasurer; Geo. Wilkins, M.D., secretary. A committee was named to look out for a site for the erection of the necessary buildings, and have entered upon their work. At the first annual meeting about thirty-five new life governors were elected, making the life governors of the institution at present seventy-two.

MONTREAL DISPENSARY.

The report of this institution, which was read at its annual meeting the commencement of May, shows a most satisfactory condition. Over six thousand patients received medical aid during the year. The financial condition is also most satisfactory. After placing \$500 to the credit of a building fund, a balance of \$150 is carried forward.

HOW TO CHECK COUGHS.

Dr. Brown-Sequard, in his late Boston Lectures, says that there are many facts which show that morbid phenomena of respiration can always be stopped by the influence of arrest. Coughing, for instance, can be stopped by pressing on the nerves of the lip in the neighborhood of the nose. A pressure there may prevent a cough when it is beginning. Sneezing may be stopped by the same mechanism. Pressing in the neighborhood of the ear, right in front of the ear, may stop coughing. It is also preventive of hiccough, but much less so than of sneezing or coughing. Pressing very hard on the top of the mouth inside is also a means of stopping coughing. And, he adds, that the will has immense powder there. There was a French nurse who used to say, "The first patient who coughs here will be deprived of his food to-day." It was exceedingly rare that a patient coughed then.

PERSONAL.

Dr. Cameron (McGill College 1874) has been appointed Assistant House Surgeon, Montreal General Hospital.

Dr. Cline (McGill College 1874) has been appointed House Apothecary to the Montreal General Hospital.

Dr. Robert Costigan (Bishop's College 1874) has commenced practice at 49 Russell avenue, Indianapolis, Indiana, U. S.

Dr. Valmore, St. Germain (Bishop's College 1874) has commenced practice at Minneapolis, Minnesota.

Dr. Fuller has resigned the position of Demonstrator of Anatomy to McGill College.

Dr. W. M. Hunter (Bishop's College 1874) has located himself in Cornwall, Ont.

Dr. W. E. Coquillette, formerly a student of Bishop's College, lately of Rush Medical College, Chicago, has commenced practice in Franklinville, Illinois.

Dr. Francis J. Shephard (McGill College) has obtained his diploma of the Royal College of Surgeons of England.

Sir William Moore is the new Director General of the Army Medical Department. He served with the 33rd Regiment, as Surgeon, throughout the Crimean campaign, being present with it at the battles of Alma, Inkerman, and Sebastopol. He passed through the Indian mutiny, and in 1860 was appointed principal medical officer to the expedition to China, under Sir Hope Grant. In 1862 he came to Canada, as Inspector General of Hospitals, and was in charge of the medical arrangements during the Fenian raid of 1866. Soon after he returned to England, and was appointed to a high position in India. He has now reached the highest point, it is possible for him to attain, and we are sure many in Canada, who remember his kindly disposition, and urbanity of manner, will rejoice at his success. We will be much mistaken if, under his direction, many of the abuses which press heavily on the medical department of the army are not removed.

Dr. W. E. Scott and Dr. R. P. Howard, have resigned their positions as attending physicians to the Montreal General Hospital. The former has occupied it for about twenty-seven years, and the latter for about twenty-four years. They have been elected Consulting Physicians and Surgeons to the Institution.

Dr. Roddick, formerly House Surgeon of the Institution, and Dr. Robert Godfrey, professor of Surgery, University of Bishop's College, have been elected by the Governor's Attending Physicians and Surgeons to the Montreal General Hospital, to fill

the vacancies caused by Dr. Scott's and Dr. Howard's resignations.

Dr. Thos. G. Roddick has, we are informed, been appointed Demonstrator of Anatomy to McGill College, in place of Dr. Fuller resigned.

Dr. F. J. Austin, of Sherbrooke, passed through Montreal, from Colorado, *en route* for home on the 22nd May. We are glad to know that his health has been much restored by his winters rest. We understand Dr. Austin has in contemplation, commencing practice in Montreal—his health not permitting his continuing country practice.

Dr. Fenwick of Montreal has so far recovered from his recent severe and prolonged illness, as to permit his travelling. He has been absent from Montreal several weeks.

PROSECUTION BY THE COLLEGE OF PHYSICIANS AND SURGEONS OF LOWER CANADA.

The end of April this body entered an action against a "Dr. Charles Worms" for practicing in Montreal without a license. The case was tried before the police magistrate, and the defendant was fined \$20 and costs. We are glad to note the activity on the part of the College. In Montreal, we are glad to say, we have but few unlicensed practitioners, but we hear from many of our friends that in country districts they abound to a great extent. We trust that the College will give its attention to them.

BIRTHS.

In Montreal on the 11th of May, at 37 Beaver Hall Terrace, the wife of Dr. A. Proudfoot of a daughter.

In Dunville, April 13th, the wife of G. A. McCullum, M.D., of a son.

MARRIAGES.

In Montreal, on the 28th April, by the Rev. Mr. Aoustin, Dr. Joseph Octave Cote, of Biddeford, Maine, to Mathilde Roy, of Montreal.

In Montreal, on the 21st April, Joseph Edouard Case, C. M., M. D., of St. Philomene, to Maria Josephine Ema, daughter of Ferdinand Perrin Esq., Montreal.

DIED.

At Shelborne, Nova Scotia on the 16th April, Roderic Sutherland, M.D., late House Surgeon, City Hospital, Halifax, in the twenty-seventh year of his age.

At Barton, Ont., on the 19th inst., Ruth Case, relict of the late Dr. Wm. Case, and mother of Dr. Case, sen. of Hamilton, aged 94 years, 8 months and 19 days.

In Toronto on the 26th April, Frederick William, infant son of J. Fulton, M. D.

In Toronto on the 26th ult., Margaret Fisher, aged 4 months, infant daughter of H. E. Buchan, M. D.

In Buenos Ayres, South America, on the 21st of January, Frederick William, aged 3 months and on the 21st of February, Carlos Guillermo, aged 17 months, sons of Dr. William H. Coventon.