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Progress of Medical Science.

TYPHOID FEVER.

By ALFRED L. LOOMIS, M.D.,

Professor of Pathology and Practical Medicine in the Medical Department of the University of the City of New York.

Prognosis.—Death may occur at any stage of typhoid fever. A typhoid patient is not out of danger until all tympanites, diarrhoea, and other abdominal symptoms, which indicate that intestinal changes are still progressing, have disappeared. Independent of complications, the duration, type, and intensity of the febrile excitement has more to do than all the other elements in determining the prognosis in any case of typhoid fever. The height of the temperature on the eighth day determines the range of temperature that may be expected on each succeeding day. If upon that day it is not higher than 104° F., or 105° F., and has been regular in its development (independent of complications), the prognosis is good; in uncomplicated cases it very rarely rises higher than the degree it has reached at that time. A prolonged high temperature (above 105° F.) after the first week renders the prognosis unfavorable.

In mild cases, during the second week a marked morning remission occurs, which begins early and continues until mid-day; the evening exacerbation is late, and by the end of the second week there is a marked and permanent fall in the temperature. In severe cases, the opposite conditions are observed. A sudden rise in temperature, or a rapid and extreme fall at any period of the fever, is a very bad omen; the latter often precedes the occurrence of a severe intestinal hemorrhage. Marked variations from the typical temperature of the disease indicates the existence of complications. Slight decline, accompanied by great fluctuation of temperature, during the third week, is an unfavorable symptom. The natural power of an individual to resist disease, especially the effects of prolonged high temperature, is a very important element in prognosis. The organ which is the surest indicator of such power (especially in typhoid fever), is the heart. If the pulse is full and regular, perhaps beating at the rate of 110 or 115 per minute, if the cardiac impulse is good, and a distinct first sound can be heard, even though at the end of the second week the temperature stands as high as 106° F., the prognosis is favorable. If, however, the pulse has risen to 120 or 130 per minute, if the apex beat is feeble or imperceptible, and the first sound of the heart is indistinct or altogether obscure, with a tendency to cyanosis and pulmonary oedema, the indications are that the patient's powers of resistance are failing, and

under such circumstances the prognosis must be unfavorable. It is not so much the rapidity, as the regularity, a sudden falling and a sudden rising of the pulse, that indicates the impending danger. The rapid rising of the pulse upon the slightest excitement is the most unfavorable indication, as it shows extensive heart-failure and a rapid giving way of vital power.

Age.—The influence of age is very great in determining the prognosis in any case of typhoid fever.

The prognosis is much better in children than in adults. Occurring in persons over forty years of age, the prognosis is decidedly unfavorable, even though the symptoms may not indicate a severe type of the disease.

In the case of those individuals who habitually use alcoholic stimulants, whose powers of resistance to high temperature is diminished, the rate of mortality is very great.

The puerperal state renders your prognosis especially unfavorable. The danger to the patient is equally great, whether the fever comes on prior to delivery or during puerperal convalescence.

In this fever there is greater danger to those who are suffering from any form of chronic disease, than to those who are in a healthy condition at the time of the attack.

The complications which influence prognosis are more numerous than those in any other disease.

I shall briefly allude to those which are intimately connected with, or dependent upon, the morbid changes ordinarily incident to the disease, and afterward speak of those which may be designated as accidental complications.

The parenchymatous changes which take place in the different organs of the body, during the progress of this fever, necessarily influence prognosis. For instance, the muscular degenerations of the cardiac walls and the consequent loss of heart-power, which favors pulmonary and other hypostatic congestions, and the diminished quantity of blood sent to the various tissues of the body, interfere more or less with their nutrition. Necrotic and gangrenous processes, sometimes met with in the cellular tissues of the surface, and along the line of the intestines, also the venous thrombi which so frequently develop in a protracted case of this fever, are, to a certain extent, the result of this cardiac weakness. It is apparent that the development of extensive cardiac degenerations must render the prognosis unfavorable.

Excessive cardiac weakness favors the development of blood-clots in the heart cavities; these may break up and cause embolism somewhere in the course of the general circulation, and thus lead to changes which may destroy life. Again, intestinal perforations, one of the results of the intestinal changes incident to the

fever, render the prognosis most unfavorable. The same is true of copious intestinal hemorrhages coming on after the third week of the fever, as well as of all those glandular changes which are a part of the natural history of the fever, and which I have already described.

Any of these changes may lead to complications which endanger the life of the patient, and consequently when they occur, necessitate a guarded, if not an unfavorable prognosis.

Some of the prominent accidental complications which may occur in the course of typhoid fever, but which do not belong to its regular history, have their seat in the respiratory organs. Slight bronchial catarrh is present in nearly every case, and can hardly be regarded as a complication. It is so much a part of the clinical history of the disease, that some have named this fever bronchial typhus. There is another much more serious bronchial complication, namely, catarrh of the smaller bronchi, or capillary bronchitis. This usually comes on during the second or third week of the disease, and, if extensive, greatly endangers the life of the patient. If then during this period of the fever you have sub-crepitant râles suddenly developed over the whole of both lungs, accompanied by great dyspnoea and an abundant expectoration of stringy mucus, you are warranted in giving an unfavorable prognosis.

Extensive œdema of the lungs occurring with, or independent of, capillary bronchitis and pulmonary congestion, sometimes comes on suddenly during the third week of typhoid fever, and indicates great failure of heart-power. The slightest indication of its occurrence should always be regarded with suspicion. It is not unfrequently accompanied by more or less extensive hemorrhagic infarctions of the lungs; these depend on embolism of some of the branches of the pulmonary artery, due to fragments of clots which have formed in the right side of the heart, the result of the cardiac weakness. They often lead to gangrene of the lung. It is sometimes impossible to diagnosticate their existence during life.

Pneumonia, when it complicates typhoid fever, is generally latent. It comes on very insidiously, and, unless you are on the watch for its development, and make frequent and careful physical examinations, it will pass unrecognized. It is more frequently developed during the third and fourth week of the fever, and usually is catarrhal rather than croupous in character. At first only single lobules are involved, but after a time an entire lobe becomes consolidated. When irregular variations in temperature occur during convalescence, or during the third or fourth week of the fever, there is reason to suspect the development of pneumonia. In the majority of cases the characteristic pneumonic cough and expectoration are absent. Whenever an extensive pneumonia complicates typhoid

fever, the prognosis is especially unfavorable.

Pleurisy does not occur so frequently as a complication of typhoid fever, as does pneumonia or bronchitis. When it does occur, pus is almost invariably the product of the inflammatory process. Usually it comes on late in the disease, comes on insidiously, and is quite likely to pass unrecognized unless frequent physical examinations of the chest are made. In many instances it is really a sequela of the fever, not developing until three or four weeks after the fever has run its course. Its occurrence must always be regarded as unfavorable; for a year or even longer time must elapse before recovery can take place, and even then recovery is doubtful.

Occasionally, laryngitis is a serious complication of this fever. It generally occurs in those cases where the fever has been very protracted, and there is great prostration. Its presence is marked by sudden and very intense inflammation of the mucous membrane of the glottis, which is liable to become œdematous, when death may suddenly occur. It may lead to ulceration of the mucous membrane. Whenever, during any stage of a typhoid fever, the characteristic symptoms of laryngeal obstruction occur, remember the danger of œdema glottidis and of extensive laryngeal ulceration, and promptly resort to those means which shall relieve the unpleasant symptoms, and avert the danger which threatens your patient.

Pyæmia may be met with as a complication during convalescence from typhoid fever, but it is not of as frequent occurrence as septicæmia. Whenever we have septic poisoning developed, with extensive sloughs in the intestines, the prognosis is exceedingly unfavorable.

Acute gastric catarrh is another complication of this fever, the possible occurrence of which must enter into your prognosis. A patient may have reached his fourth week, and be rapidly convalescing, his desire for food returning; you endeavor to hasten his recovery by increasing the quantity of food taken, or by allowing him to partake freely of such articles of food as are difficult of digestion. The result of this overcrowding, or of imprudence in diet, is irritation and inflammation of the enfeebled gastric mucous membrane. Vomiting of a stringy mucus occurs, which, by its prostrating effects, endangers or destroys the life of your already enfeebled patient. I would impress you with the importance of exercising the greatest care in regard to the diet of patients convalescing from typhoid fever. They should be restricted to milk and nutritious broths in moderate quantity until all danger from this complication shall have passed.

Disturbances of nerve function have been considered under the head of symptoms, but, not unfrequently, certain brain and nerve

lesions are developed, which cannot be classed under that head.

Cerebral œdema may complicate a typhoid fever during its third week, and give rise to symptoms of a grave character. A decided enfeebling of the mental powers, and a tendency to stupor, announces its occurrence.

Hæmorrhagic extravasations on the surface, and into the substance of the brain, the result of degeneration of the walls of the cerebral vessels, occasionally occurs during the height of the fever. If the effusion is moderate, no marked symptoms are developed, but if a considerable extravasation takes place, it gives rise to symptoms of cerebral compression.

Meningeal inflammation is a rare complication.

The occurrence of any of these complications in any case renders the prognosis unfavorable.

You must remember that during the second or third week of the fever certain cerebral disturbances may occur, which seem to indicate the existence of some one of these complications, when really no cerebral lesion exists. Usually, these are present in patients who have had a continuously high temperature; in favorable cases they disappear after a few days. These have been referred to under the head of symptoms.

You will encounter various other disturbances of the nervous system, such as hemiplegia, paraplegia, etc., which may simulate those due to lesions of nerve centres, or local forms of paralysis and anæsthesia, which seem to be confined to individual nerves; but as these functional disturbances do not depend upon any anatomical changes, the prognosis in such cases is good.

Those changes in the kidney which are due to the parenchymatous degeneration which usually attends this fever, have been already noticed; but occasionally nephritis is developed as a sequela. The urine becomes scanty, is loaded with albumen, and contains blood and casts; the face and extremities become œdematous, and death may occur from uræmia. The occurrence of this complication necessarily renders the prognosis bad.

In a few instances under my observation, severe catarrh of the bladder had developed during convalescence, greatly complicating the case; in one instance the cystitis was accompanied by pyelitis.

Suppurative inflammation of the cellular tissue of the body, or cellulitis, especially of the surface, often complicates convalescence, and in some cases causes death. It is most liable to develop in those parts which have been subjected to long-continued pressure. Occasionally it is met with in the pharynx, and along the line of the lymphatics.

Accompanying these cellular inflammations, or occurring independently of them, not

unfrequently gangrenous inflammations of the integument occurs, giving rise to what has been called *bed-sores*. These gangrenous processes are most frequently developed at those points which have been subjected to the greatest pressure, on account of the position of the patient, such as the sacrum, nates, heels and shoulder-blades, etc. In the simplest form of *bed-sores* there is only a superficial loss of substance; in more severe cases the subcutaneous cellular tissue is involved; and in the worst cases the muscles and fibrous tissue. I have met with cases where the slough had involved the connective tissue and muscles, and laid bare the bony tissue.

A considerable number of typhoid patients who have lived through the fever die either from the exhausting effects of these *bed-sores*, or from the septic poisoning resulting therefrom.

The possible occurrence of these complications must enter into the prognosis in every severe case, and the earlier they make their appearance the greater the danger.

We have now completed the list of principal complications which are to modify your prognosis in any case of typhoid fever. Before leaving the subject, I will say a word in regard to the *duration* and *mode* of termination of this fever.

Its average duration is from three to four weeks; a typical case extends over a period of four weeks. When the fever is protracted beyond the middle of the fourth week, in most instances this is due to some complication or to an extension of the intestinal ulceration. The period of greatest danger is at the close of the third week. Death rarely occurs before the fourteenth day. The prominent direct causes of death are: 1st. Toxæmia; 2d. Asthenia; 3d. Suppression of the excretory function of the kidneys; 4th. Hyperæmia and œdema of the lungs; 5th. Intestinal hæmorrhage; 6th. Exhaustive diarrhœa; 7th. Intestinal perforation; 8th. Peritonitis, with or without intestinal perforation. In nearly all cases the failure of heart-power is directly or indirectly the cause of death.

Relapses.—After typhoid fever has run its course, and after the patient is entirely free from fever, quite frequently we have a new development of the fever; these developments are called relapses. Their course corresponds with that of the primary attack, only they are of shorter duration. The temperature rises more rapidly, the eruption reappears, the spleen enlarges, the intestinal and abdominal symptoms return, and all the prominent symptoms of the primary fever are rapidly developed. As a rule, the relapse is milder than the primary attack. If it terminate fatally the post-mortem examination shows, in addition to the cicatrizing intestinal ulcers of the primary attack, the recent intestinal changes of the relapse. The lesions of the relapse, although of the same character as

those of the primary attack, are less extensive.

It is very difficult to give a satisfactory explanation of these relapses. Some claim that they are the result of certain plans of treatment, especially the cold-water plan. This assertion lacks proof. Again, others hold that all relapses depend upon a new infection. Perhaps this is possible if the patient remain in the same locality and has the same surroundings as when he had the primary attack; but how shall we explain relapses in those who are removed from all the sources of the primary infection? Another explanation offered is, that a part of the typhoid poison has remained in the system, undeveloped during the primary attack, and that some time after this has passed the poison reproduces itself and sets up a second fever.

A more recent theory is, that the typhoid poison thrown off in the feces of the patient is reabsorbed and causes the relapse. Unquestionably, it is possible for healthy glands to become inoculated by sloughs thrown off from those first affected.

In many cases it is impossible to account for the occurrence of the relapse, and all of these explanations as to the cause in any case are more or less unsatisfactory.

In those cases which have come under my own observation, I have noticed that the splenic enlargement which has existed during the course of the fever does not subside with its decline; and that the tenderness along the line of the intestines, especially in the right iliac region, continues during the period between the original attack and the relapse. In some instances, apparently, the relapse has been brought on by indiscretion in diet, or by injudicious exercise on the part of the convalescent patient. Occasionally relapses have occurred when great care had been taken against any indiscretion or over-exertion.—*New York Medical Record.*

PUERPERAL FEVER AND SEPTICÆMIA.

Dr. Geo. Hunter read before the Medico-Chirurgical Society of Edinburgh (British Med. Journal, September 23, 1876) a paper on Puerperal Fever and Septicæmia, their relations and probable identity, with cases. He first alluded to the difficulty felt by the practitioner in publishing cases of puerperal fever; and then described some cases in his ordinary practice which preceded the puerperal ones. Two were in the same house; the husband had diffuse cellulitis of the arm after a puncture which nearly proved fatal, and his wife had a very bad attack of erysipelas. Other cases of erysipelas had large abscesses and great fetor, and one especially required very constant dressing and care by Dr. Hunter's own hands. The puerperal-fever cases were six in number, of which four died and two recovered. These cases were coincident with some most curious and serious results on the health of their nurses and families. *E.g.*, the mother of one, who nursed her, had axillary abscess of a most severe

type, with great prostration. Her sister, who succeeded her mother as nurse, had a most dangerous inflammation of finger, hand, and arm. The servant-girl, who washed the linen, had fever and sore-throat, and the husband a slighter form of the same in his tonsils. Another case similarly affected her mother, husband, three sisters-in-law, who all acted as nurses successively, and the husband of one of the latter. Dr. Hunter, by an exhaustive process of reasoning, traced out the chain of phenomena, and ascribed the commencement of the whole to the thoroughly septic condition of his own hands after the two cases of erysipelas and abscess first alluded to. He described the extreme precautions he took as to cleanliness, and their good effect when once undertaken.

Dr. Simpson thought the society, and indeed the whole profession, were indebted to Dr. Hunter for his paper. It certainly required a great deal of courage to bring forward the series of disastrous cases so admirably detailed. The question now was, were we to retain the term puerperal fever? In the discussion previous to Dr. Hunter's paper there was a variety of fevers in women, all puerperal, because they occurred in the puerperal state. Thus, when typhoid fever or small-pox laid hold of a puerperal woman, there was danger of death, because she had never had them before. In one case of a lady, who had been sedulously guarded from infantile diseases, an attack of measles in her thirteenth confinement proved fatal in a few days. Now, were we to look on puerperal fever as identical with erysipelas? Sometimes the erysipelatous poison coming into contact with the vaginal or other canals caused symptoms similar to those arising after a surgical operation. Then there was the group of cases so well brought forward by Dr. Hunter, where the surgeon got impregnated with a poison which would give a surgical patient a fever with local manifestations from the introduction of poisons into a wound. This, as taught by the late Sir James Simpson, should be held as puerperal fever when the patient was a puerperal woman. There were two things, however, required from Dr. Hunter; viz., post-mortem examinations of the women who had died, and also of the fatal surgical case. This would, no doubt, have shown lymphatic inflammation, phlebitis, thrombosis, and metastatic inflammation. He had collected for his late uncle, in the dissecting-rooms at Vienna, the results of post-mortem examinations of patients dying after puerperal fever and after surgical operations. The results in both classes of cases were the same, especially where the surgical operation had been on the abdomen. The great danger in a puerperal patient lay in her condition. It would have been interesting to know the health of the puerperal women in the district at the time of Dr. Hunter's fatal cases, as it would have added to the value of his paper. He had undoubtedly carried a morbid agent; and it was, therefore, important to watch the kind of source from which such an agent might arise. Dr. Hunter had done so in his cases, but it might come from less striking sources. Thus, in a case of his

own, it was traced to the sore thumb of the nurse; and in a second instance it was also traced to the nurse, who had been dressing an old ulcer. Then, again, the obstetrician might get the poison from the fetid lochial discharge of a patient already confined, although it was doing the woman herself no harm. He felt much interested in Dr. Hunter's cases, and felt sure they all owed him thanks for it.

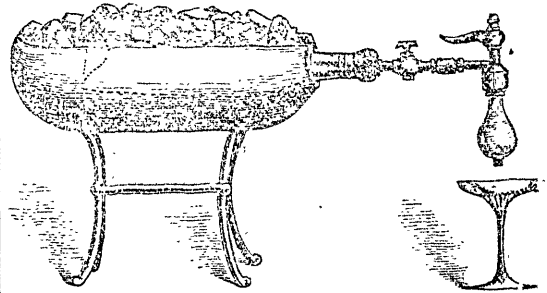
Dr. A. Macdonald wished simply to indorse Dr. Simpson's remarks. The contribution was valuable, and one much needed in science. There was always a certain amount of reluctance in furnishing such cases; and although the practitioner was honored by his brethren, yet the popular amount of credit was not in proportion to his deserts. No member would deny the view of puerperal fever advocated this evening. The only question was the bearing of antiseptic measures on these cases; whether by the diligent use of antiseptic agents such organic fever-poisons could be destroyed. He would fain believe such was the case. It might be true, as Dr. Hunter had said, that the epidermis of the hand might be so impregnated that so much poison might lurk in its deeper layers as to cause puerperal septicæmia even after a three-weeks' holiday on the part of the medical attendant. He did not, however, think that their present knowledge warranted this. Probably, if the cases were examined, some hidden relationship between them and other causes might be traced different from what Dr. Hunter had shown. Then they knew that carbolic acid caused desquamation of the cuticle; and most of them would demur to the case of pyæmia where the pulmonary mucus membrane was supposed to be the absorbing medium. It was more probably a scratch in some accessible part. These were the doubts that occurred to him; and if it were true that these poisonous influences—bacteria, etc.—were so subtle that no carbolic acid could kill them, then no obstetrician nor surgeon could, after a sinking wound, go to cases for weeks. —*Ext. from Monthly Abstract of Medical Science.*

WARKER'S IMPROVED SYPHON.

MR. THOMAS WARKER, of New York city, has devised an apparatus for the administration of sparkling wines, which promises to be of the greatest utility to physicians. It is well known, whenever wines charged with carbonic acid gas are prescribed for our patients, that after the bottle containing it has been opened and the first dose is taken, that most, if not all of the sparkle disappears, and, as far as any good to be obtained from the gas itself is concerned, it is virtually inert. The French contrivance of introducing a faucet with stop-cock through the cork, although apparently sound in theory, was found radically defective in practice. The wine was discharged with a spurt, and with considerable force, but contained little or no gas after the first glass was drawn. Mr. Warker, after a careful study of this phenomena, discovered that the object aimed at in this and all other similar contrivances—namely, the discharge of the wine under pressure—was the real cause of the loss of the gas in the glass. This

theory, it seems to us, is abundantly substantiated by the ordinary method of obtaining the wine from the bottles. The operation of removing the cork is the signal for the discharge of the extra and supernatant pressure; the wine is then simply poured in the glass, and, if not allowed to stand too long, retains its accustomed sparkle. If, however, the entire contents of the bottle are not used within a reasonable time after being opened, we have also a loss of the carbonic acid which it contains. In this instance the gas escapes from the liquid because there is not sufficient pressure above to prevent it.

It is necessary to appreciate these facts in order to understand the principles upon which his contrivance is based. His objects are, first, to maintain the pressure in the bottle, or the ordinary syphon, as the case may be; and secondly, to discharge given quantities without subjecting them at the moment of their discharge to any pressure whatever.



The apparatus, as seen in the cut, consists of a bottle of champagne, the cork of which is perforated for the reception of a tube connected with an extra or receiving chamber. When a small quantity of wine is to be drawn, a direct communication is opened between the chamber and the bottle by means of a valve, and, when a sufficient quantity of wine has escaped in the small receptacle, the valve is closed. The bottle and the extra chamber are then entirely independent of each other, and the pressure in each is relatively the same, and can be so maintained as long as desired. When the wine in the chamber is required, the opening of a compound valve relieves the pressure of the supernatant gas, and the wine thus relieved gently flows into the glass, containing even more gas than when poured from a freshly-opened bottle. As can easily be seen, this operation can be repeated with the same result until the bottle itself is exhausted. The practical application



of this principle enables the physician to prescribe sparkling wines not only from syphons, but from the original bottles, and still preserve the sparkle until the entire contents are used. Aside from this, means are now afforded, by attaching this supplementary chamber to the nozzle of the ordinary syphon apparatus, of charging still wines, brandies, and even noxious draughts with gas, and administering them to our patients ad libitum. The

question which naturally suggests itself in this connection is, why champagne and similar wines cannot be treated as the ordinary mineral waters, which are known to retain a certain amount of gas when discharged under pressure. The answer to this is, that Mr. Warker has found that, while mineral waters will so behave, the wines are governed by a different law, and hence the opposite result. Another advantage of this contrivance is the possibility which it affords of administering the different mineral waters charged with gas, and at different temperatures. Carlsbad, for instance, can be drunk at its natural elevated temperature, without suffering from the loss of its carbonic acid, which would be the case under other circumstances. Altogether, the scientific principle involved in this contrivance is as interesting to the physician as its practical application is destined to be beneficial to his patients.—*N. Y. Medical Record*, December 2, 1876.

LISTER'S ANTISEPTIC METHOD IN OVARIOTOMY.

By J. MARION SIMS, M.D., New York.

PROFESSOR LISTER'S late visit to this country seems to have given a new impulse to antiseptic surgery. Van Buren has adopted it with success, and is lecturing on it to his class at Bellevue with great enthusiasm. Stephen Smith has also adopted it with the same success, and is teaching it most earnestly to his class at the University, and other surgeons must take it up. I have often wondered why it had not been used in ovariectomy. Lister told me it had not been done in Great Britain. He advocated it strongly, but Spencer Wells and Keith have had such wonderful success in their operations, that they did not feel justified in trying any new method.

I would have used it long ago if I could have found a convenient and ample spray-producer.

A fortnight ago I heard that Dr. Sass had perfected an apparatus, and had tested it in operations by Van Buren, Stephen Smith, and others. I saw Dr. Sass, and he kindly consented to bring his apparatus, and apply the carbolic spray for me in a case of ovariectomy.

The patient, forty-seven years of age, noticed a tumor, the size of an orange, in the right iliac region last April. She consulted her family physician who pronounced it an ovarian tumor. In June she consulted Dr. Thomas, who wisely told her the time had not arrived for an operation. On the 20th July she went to Philadelphia to see Dr. Atlee, who gave her the same good advice. I saw her on the 20th September. I have never seen any one so anxious for an operation. I dissuaded her from it, advising her to return home and wait at least till next spring. I told her the tumor did not weigh more than ten pounds, and that an operation was not justifiable till she vomited her food and began to emaciate. I saw her a month later. She declared she had not the strength to make the journey home, and that she threw up every time she took food. I still refused to operate. She wrote to Dr. Atlee, and he replied on the 6th November: "I can scarcely think a tumor

so small can affect your general health so seriously. But if your emaciation and debility are the result of the presence of the tumor, then by all means it should be removed." I believe her vomiting and consequent emaciation were mainly the result of mental and moral causes. Whatever the cause, her declining strength and a recent fugitive attack of peritonitis warned me not to procrastinate the operation any longer.

The operation was done on Thursday, the 23rd November last. I am particular in fixing the date because I believe it inaugurates a new departure in ovariectomy.

Dr. Sass directed the spray which covered the seat of operation with a delicate carbolic mist. The hands, sponges, and instruments were all dipped in carbolic water. The operation and dressing lasted forty minutes, the spray being kept up all the time. It could have been continued two hours, if necessary. There were no adhesions. The peritoneal cavity contained six or eight ounces of a reddish serum. The peritoneal membrane was everywhere deeply congested. This fact explains the presence of reddish serum, and the previous attack of peritonitis.

The pedicle was very short, and at least three inches broad. It was tied in three sections with strong twine, and drawn out and fixed in the lower angle of the wound, clamp-fashion.

The external incision was closed by sutures, and a carbolic dressing applied.

The pulse never rose above 90, nor the temperature 101.

Convalescence was fully assured in forty-eight hours, and the patient is now quite well. The tumor was polycystic on right side, and weighed fifteen pounds.

I hasten to lay this case before the profession merely to urge the adoption of Lister's antiseptic method in ovariectomy, which, I am sure, will prove as valuable in this operation as it has in general surgery.

Dr. Sass's apparatus answered its purpose admirably, and I think he has rendered us a great service in bringing it before the profession at this time.—*N. Y. Medical Record*, Dec. 9th.

SIGNS OF THE FIRST STAGE OF PHTHISIS.

It is so all-important to recognize phthisis at its inception that we quote the following summary from a lecture in the *Lancet*, by Dr. Jas. Edward Pollock:—

The *first stage*, which consists in a filling up of the alveoli by inflammatory or tubercular products, is recognizable by the signs which indicate altered physical conditions of a portion of the lung. In health we hear the gentle vesicular murmur caused by the entering air, followed by an equally gentle expiration-sound as the air is expelled, and the percussion-note is even on both sides. The voice scarcely resounds through the elastic air-tubes, but communicates a gentle purr or fremitus to the hand when applied to the chest-walls. But if a portion

of lung be solidified surrounding a pervious air-tube all this is altered. There is a dull note on percussion, because less air is under the finger. The entering air-sound may be *feeble*, *harsh*, or *jerky* and interrupted; the expiration-sound is prolonged unduly; while the voice-sounds are propagated to the ear as through a tube, and the heart's sounds are also conducted. Now these are common to the first stage of phthisis, but why? All that auscultation can tell you is that a portion of the lung has several of its physical conditions altered, but of the nature of the product which so alters them it can tell you nothing. That knowledge can only come to you by a study of the other relations of your case. Let us try these alterations by their meaning.

Feeble respiration may be due to obstruction in one or more bronchioles, by pressure on their walls or narrowing of their calibre; by any obstacle to air entering, as a tumor or a foreign body in the brouchus; by anything which increases the distance of the lung from the ear, as effusion into the pleura or by a thickened pleura; and by emphysema, which impairs the elasticity of the lung.

Harsh breath-sounds may be due to thickening of the walls of the air-cells, whereby their elasticity is impaired, by induration causing pressure on the alveoli, and by dryness of the mucous membrane of the bronchi.

Prolonged expiration depends on a difference in the density and an alteration in the elasticity of the lung, whereby a sound naturally feeble is developed and rendered more audible.

The *bronchial* or *tubular* character of the breath-sounds and voice is caused by the increased conducting power of the solidified lung, and excessive audibility of the heart-sounds means the same.

The *wavy* or *interrupted* inspiration sound is only valuable when permanent and conjoined with other sounds which indicate solidification, as a whiffy or tubular character of breathing. It is probably caused by alterations in the elasticity of the alveoli and their irregular expansion.

Now if you can group several of these signs in any one case, and if dullness co-exist, and the space presenting these phenomena be limited in extent and one-sided, you may be sure that some solidifying alteration has taken place in and around the alveoli of that part of the lung. But if this condition be preceded by slight loss of flesh, sub-febrile symptoms, and with dry cough or a scanty flocculent expectoration, you may be pretty sure that you are dealing with the early stage of phthisis. But you only know your patient's present state: the future is masked or may be altered by various other agents than those now evident to you. Physical evidence is always true, but the inferences may not always be correct. I have pointed out to you that even from this state of things there may be recovery; the alveoli may collapse, the chest-walls fall in, the morbid product in the lung undergo degenerative change, dry up, and be expectorated, and a little flattening and dullness alone betray the nature of the attack.

UROCYSTIC AND URETHRAL DISEASES OF WOMEN.

By ALEX. J. C. SKENE, M.D., Professor of Gynæcology in the Long Island College Hospital, Brooklyn, N. Y.

GENTLEMEN:—Progress in the study of pathology enables us to understand more fully the various changes of structure which give rise to deranged action on the part of the various organs of the body, and therefore we have more *organic* diseases on our present list, and fewer *functional* disorders.

The rule has been to call any trouble a functional disease when we could discover no change of structure in the case. On the other hand, improved means of investigation now enable us to ascertain more positively that in certain deranged functions, the organs involved are normal in structure. This is particularly applicable to the derangements of the bladder in the female.

There are several functional disorders of the bladder due to diseases outside of the organ itself, and in order that you may easily follow me in what I have to say about these derangements, let me enumerate the various ways in which the function of the bladder may be disturbed.

1. Frequent urination.
2. Difficult urination and retention.
3. Painful urination.
4. Pain after urination.
5. Incontinence of urine.

The majority of these deranged actions on the part of the bladder may be due either to functional or organic disease. Those purely functional I shall now tell you about.

In the variety of conditions of the nervous system grouped under the head of "hysteria," we often observe that frequent urination is a prominent symptom. The cause, in many cases, is the peculiar character of the urine secreted in this disturbed condition of the nervous system. The limpid urine of hysterical patients is deficient in solids, the watery portion being greatly in excess. This unnatural composition renders the urine irritating to the bladder, so that it cannot be long retained. The quantity of urine secreted is also excessive, which, together with the irritating quality of the fluid, renders urination necessarily very frequent.

But apart from the frequent urination which occurs, for the preceding reasons, in severe attacks of hysteria, we often see cases of frequent evacuation which can only be accounted for by the state of the nerves which govern the action of the bladder. When the quantity and composition of the urine are normal, and the patient can retain it without pain or distress during the night, but has to pass it every hour or two during the day, we may safely conclude that the trouble is purely functional, and due to a

disordered state of the nervous system. The only condition which resembles this history is occasionally seen in prolapsus, the patient being free from trouble while reclining, but has to urinate frequently when in the erect position.

Another class of cases resembling the hysterical patients in the frequency of urinating, but differing in every other respect, we find in those who suffer in consequence of the habit of masturbation. The constant congestion and irritability of the pelvic organs, caused and kept up by the unnatural and excessive exercise of this sexual function, give rise to frequent urination. Such patients complain of general weakness, which is not accounted for by any organic disease of the general system. Nor is there disease of the bladder; it is simply enfeebled and irritable like the rest of the pelvic organs. To make a correct and positive diagnosis in such cases is by no means easy, because it necessitates our detecting the habit of masturbation, and this is usually one of the most difficult tasks for the diagnostician. It is not always prudent to question the patient regarding the habit; and even when we do, they frequently fail to comprehend the question, or they answer falsely in the negative. We are thus generally left to guess at the truth of the matter.

The symptoms developed by masturbation are depression of the nervous system, manifested by lassitude, sadness, or emotional manifestation of joy and sorrow—easily affected to smiles or tears. The eyes are dreamy and heavy, and the pupils dilated. Such subjects are excitable, irritable, and easily exhausted. They often have headaches. Nutrition is apparently good in some cases, as shown by the fair supply of flesh; still they often suffer from acute indigestion, although at times the appetite is remarkably good. The bowels are usually constipated, and the muscles are soft and flabby. The exhalations from the skin are changed in some cases, so that a peculiar odor is noticeable about such persons. This odor cannot be described, but when once experienced can be easily remembered.

In all this class of functional derangement of the bladder from neurotic causes, the symptoms vary in severity to a great extent in the same individual. The trouble is by no means regular and constant in its manifestations as in organic diseases. Whatever disturbs the nervous system will increase the disorder. The rule is, that frequent urination is the prominent trouble, but occasionally painful micturition is complained of. It is then simply a slight scalding pain experienced when the urine is passing over the irritable or chafed mucous membrane about the meatus urinarius.

Hysterical patients frequently suffer from retention of urine. Some of them complain for a time of difficulty in emptying the bladder, and finally fail to do so altogether. At other times

they all at once find that they cannot urinate. There are conflicting views regarding the cause of this retention, some believing that such patients can't urinate, and others that they won't. Those who believe that the trouble is feigned, not real, do so on the ground that in this morbid state of the nervous system they enjoy catheterization, which would be distressing to any one of healthy mind and body. Others claim that in the extreme sexual excitement which occurs in some cases of hysteria, the chronic erection of the clitoris makes pressure upon the urethra, and prevents the flow of the urine through the then compressed urethra. I am satisfied that both kinds of cases occur. There are those who complain of retention when they know that the doctor will use the catheter, but they can urinate easily when they please. Others I have seen who were suffering from excessive and painful distention of the bladder, and would have gladly relieved themselves if they could. Retention of the urine from this cause occurs in the amorous, who either do not practice masturbation, or who have broken off the habit.

The function of the bladder is frequently deranged from diseases of the general system, and by affections of the other organs of the pelvis. In many of the acute diseases, where the urine is loaded with solid constituents, urination is often painful. This symptom is usually accounted for by the fact that it occurs during the constitutional disease, and passes off, as a rule, in a short time.

The effect of malarial poison on the bladder and urethra is very peculiar, and requires a notice in this connection. The trouble produced in this way has been called urethral fever, and is described as an inflammation of the mucous membrane of the urethra. It might more properly be called malarial fever of the urethra. As I have observed this affection, the bladder and urethra are usually both affected, but I do not consider the disease one of a well-defined inflammatory character. There are usually symptoms of malaria present, but not necessarily chill and fever. On the contrary, I believe that I have observed the trouble more frequently in remittent than in intermittent fever, and very often where the constitutional symptoms were not more than a slight derangement of the digestive organs with moderate elevation of temperature in the after part of the day.

The symptoms vary, but usually are as follows: The patient complains of frequent desire to urinate, and some vesical tenesmus; severe burning pain on passing water, with stinging and burning in the urethra after urination. The history of such cases resembles acute gonorrhoeal urethritis so far as the abruptness of the attack and the tenderness and pain of the urethra are concerned, but there is usually

no discharge, or at least very little. Under the proper treatment the disease disappears as promptly as it comes on. In many cases the suffering is greatest in the afternoon and early part of the night. The treatment is simple, and usually very satisfactory. Quinine* in full doses for one day, followed with small doses before meals for a week, will cut short the trouble, and prevent its return. The digestive organs require attention when they are out of order; as they generally are.

Functional disorders of the bladder, caused by diseases of the other pelvic organs, are frequently met in practice. In this class the bladder trouble is secondary to some primary and more important affection, but the derangement of its function is often the most troublesome and most prominent symptom, hence it is important to understand its relations to the primary disease in order to make a correct diagnosis. This class of functional disorders frequently resemble in history some of the organic diseases of the bladder, so that care is necessary in order to distinguish the one from the other. What I may say on the subject will have reference to diagnosis only. When we know that the trouble of the bladder is due to disease of some other organ, attention is at once turned to the primary trouble; but we must keep in mind these facts when we are investigating the derangements of the bladder.

Diseases of the rectum often affect the bladder sympathetically. Irritation and pain of the rectum, from any cause, affects the bladder less or more. Chronic hemorrhoids will cause frequent urination, and so will rectal fissures, especially after defecation. Abscesses in the neighborhood of the rectum will frequently cause retention of the urine. Very troublesome irritation of the bladder comes from ascarides. The itching of the anus and rectum caused by these troublesome little worms keeps up an almost constant desire to urinate. Children are the most troubled with these parasites, but women often suffer in the same way.

Acute pelvic peritonitis and cellulitis cause great distress in many cases by their effects on the bladder. A constant desire to urinate, without the ability to make straining efforts to accomplish the object, are very often observed in all these acute pelvic inflammations. The disturbance of the bladder is of course only a symptom of the more important and primary trouble, and requires only to be mentioned here. The after effects of pelvic peritonitis on the bladder is what I especially desire to call attention to at present.

The adhesions formed by the products of the inflammation of the pelvic peritoneum are in some cases sufficient to prevent the distention of the bladder and frequent urination is then a

necessity. This derangement of function generally exists alone. The urine is retained without trouble up to a certain amount; it is passed without pain, and no vesical tenesmus follows evacuation. Unless the contraction of the bladder is extensive and the frequent necessity to urinate very troublesome, patients rarely consult us for the trouble.

Resembling this form of deranged function of the bladder are the troubles which come from displacement of the uterus. In all dislocations of the uterus the bladder suffers less or more. In prolapsus the bladder is drawn down, and cannot expand with the same facility, or else the extra traction on the utero-vesical ligaments produced by the prolapsus increases the irritability of the bladder. Whatever the explanation may be, the fact is that in prolapsus uteri the subject cannot retain the urine for the usual length of time.

Frequent urination from this cause is as marked in prolapsus in the first degree as in more advanced stages of the trouble. When the displacement has existed for a considerable time, the bladder accommodates itself to the new relation of things, and the calls to urinate become less frequent.

In complete prolapsus of the uterus and bladder, we find, in place of frequent urination, difficult urination and in rare cases retention. I presume that in such cases the bladder is never completely emptied. The little urine which remains decomposes and in time causes cystitis, which greatly increases the suffering of the patient. Such cases are very much like the cystitis which in old men comes from partial retention of the urine caused by enlargement of the prostate gland.

Anteversion usually causes frequent urination in a more marked degree than prolapsus. In this displacement the uterus is generally enlarged and elevated, so that the body and fundus rest upon the bladder and impede its distention.

Retroversion affects the bladder the same as prolapsus, except when the uterus is very much enlarged and is thrown backward and impacted in the pelvis, so that the cervix presses firmly on the urethra. In such cases urination is impossible. Examples of this are seen in retroversion occurring in the early months of pregnancy or after confinement.

Functional derangement of the bladder, arising from the various forms of displacement of the uterus, is characterized by one peculiarity, and that is, that the trouble is aggravated by the patient standing or walking, and relieved by lying down. You can usually tell that the frequent urination is caused by displacement when the position of the patient so affects the symptoms. The exceptions to this rule are very rare, but one of these I related in my previous lecture.

* Bricheleau, *Archives General de Medecine*, was the first to give quinine in urethral fever.

I have observed that patients with anteflexion often suffer from frequent urination, but I have not been able at all times to say whether the trouble was due to the fundus uteri resting on the bladder or to the supersensitiveness of the whole pelvic organs. I have inclined to believe that the latter was usually the cause.

Having thus briefly disposed of some of the more important functional disturbances of the bladder, I now turn your attention to diseases of the urethra.

Acute urethritis, though not a very frequent disease among women, is a very distressing one to the patient, and often difficult to relieve. In many cases you will find the pathology specific, *i. e.*, due to gonorrhœa; and I would treat this subject as gonorrhœa in women, were it not that it is often difficult to tell a specific or venereal urethritis from simple inflammation of that portion of mucous membrane. There is a difference in history when we can get correct testimony from the patient. Simple urethritis usually comes on gradually, and is preceded by symptoms of uterine or vesical disease; while gonorrhœa comes on rather abruptly, and is preceded or attended by acute vaginitis and vulvitis. The chief symptom is painful urination. Sharp scalding is produced by the urine passing over the tender surface. There is often a frequent desire to urinate, but not so urgent as in cystitis. In some cases the urine is retained for a long time, evidently from a dread of the pain caused in passing it.

An examination of the parts will show signs of inflammation about the meatus, with or without the same condition of the vulva. Occasionally there is a discharge seen coming from the urethra, but if the parts have been recently bathed this may not be apparent. Introducing the finger into the vagina and pressing upon the urethra from above downwards, the discharge can be started unless the patient has passed water immediately before. The appearance of the discharge resembles that of gonorrhœa in its various stages.

The treatment of acute urethritis, whether specific or not, may be conducted on the same principles as in gonorrhœa in the male, using the same constitutional remedies—local baths, etc. This will suffice in most cases of acute disease; but when it assumes the subacute form or is chronic from the beginning, then the use of injections becomes necessary. Solutions of nitrate of silver, sulphate of zinc and the like, will answer. You must bear in mind that the female urethra will not hold more than ten or fifteen drops, and if more is used it will enter the bladder, even where very slight force is used while injecting. I use a large syringe, placing the nozzle over—not into—the meatus, and inject slowly and without force a small quantity. When the case is of long standing, and the neck of the bladder appears to be in-

olved also, I use a mild injection of one or two grains of nitrate of silver to the ounce, and inject it through the urethra with force enough to enter the bladder, and let it remain there, to be passed off when the patient urinates. In old cases which began by a severe acute attack, and where the walls of the urethra are very much thickened and the canal contracted, dilation with bougies does much good. While the bougie is passed once or twice a week, I apply to the vaginal portion of the urethra oleate of mercury or the unguentum hydrargyri. This will often suffice to stop the gleet discharge, as well as remove the thickening of the urethra walls.

Another very troublesome affection of the urethra which results from urethritis, or may appear without any previous disease, is granular erosion, as it is called. The mucous membrane is covered with young, imperfectly developed epithelium; the papillæ are hypertrophied and extremely sensitive. This gives rise to the most excruciating pain during micturition, and generally keeps up a distressing tenesmus. This disease is fortunately not very common. Old people are most liable to suffer from it. The diagnosis is made from the history and appearance of the urethra. The treatment which is most reliable is, cauterization of the whole surface. The milder washes and injections do not accomplish much. Pure carbolic acid may be tried first, brushing it over the surface, and repeating it in eight or ten days. This is the least painful application, and answers in some cases. When it fails, solid nitrate of silver should be used; and when that does not suffice nitric acid or the actual cantery may be employed. Better, perhaps, than these strong caustics, is to dilate the urethra so as to paralyze the muscles, and then touch it with carbolic acid.

Vascular tumor, caruncle, or wart of the meatus urinarius, is an affection which will come under your notice quite as often as any of the urethral diseases. These growths are located in the meatus, and generally on the lower side. They have the bright red and fungous appearance of mucous polypi, such as you may have seen in the nose, ear or cervix uteri. Sometimes they are pedunculated, but more frequently sessile. They are very tender to the touch, causing the patient much distress when anything comes in contact with the diseased part. The chief trouble is the pain which they cause during micturition. They are easily diagnosed, as a rule. The bright red color of the tumor or tumors—for there are often more than one—contrasted with the normal membrane around, makes detection easy.

The only thing likely to be confounded with them is prolapsus of the mucous membrane of the urethra. This rather rare affection can be distinguished from caruncle by the tumor extending uniformly all round the meatus, and

presenting the usual appearance of a mucous membrane in a state of congestion and cedema. It can also, in some cases, be reduced when the patient is lying on the back.

The treatment of caruncle is to thoroughly remove the abnormal part. When they are pedunculated they can be clipped off, and the base touched with caustic to stop the bleeding and prevent regrowth. When they are sessile they should be destroyed by nitrate of silver, nitric acid, or chromic acid. To be able to apply the caustic to the abnormal part, and save the normal portion of the urethra, I have used a No. 10 or 11 gum catheter, having one side cut away. This I introduce into the urethra so as to bring the tumor into the notch of the catheter, and the caustic is then applied. Better still is the instrument recently described in the *Obstetrical Journal of Great Britain*, by Mr. Thomas Bryant. It is something like an ear speculum cut away on one side, and answers as a "dilator, speculum, and protector." It is an improvement on the ordinary female urethral speculum.

I have already mentioned prolapse of the mucous membrane, and I need only say here that it is a rare affection, occurring in broken-down constitutions, where there has been pre-existing bladder or urethral disease. I base this statement on one case which came under my own observation. The appearance is that of a uniform, round, red tumor at the meatus, with the opening into the urethra in the centre of it. If possible it should be returned by pushing it back, and then using astringent washes to endeavor to keep it in position; but this, I learn, usually fails, and then removal of the prolapsed portion is necessary. The quickest and best way is to take it off by the galvano-cautery. When this is not at hand the actual cautery may be employed. The most prominent portions should be touched, which will cause sloughing; and the contraction which occurs during healing will dispose of the superabundant tissue.

I ought to mention polypus of the urethra, which is one of the rare troubles, and may be classed with vascular tumor and prolapsus. No difficulty will be experienced in the diagnosis and treatment of this disease when the tumor is situated at or near the meatus urinarius. When it is situated high up, it may escape notice in the ordinary examinations. When the symptoms point to the presence of such tumor, a small speculum should be used, or the instrument of Bryant already spoken of. When the polypus is detected it should be removed. To do this, however, it is necessary, as a rule, to dilate the urethra. This can be easily and safely done by using sounds or the improved Barnes' dilators.

Recently dilatation of the urethra has been practiced very extensively. Dr. Noeggerath, of New York, has not only employed dilatation as a means of examining the urethra and bladder, but also for the purpose of admitting the finger

to explore, by the touch, all the organs of the pelvis. He was not the first to dilate the female urethra—that had been done long ago—but he was the first, I think, who dilated it for the purpose of examining the pelvic organs. In the space of a few hours he has dilated the urethra sufficiently to admit the finger, and no very serious trouble followed, which is contrary to what we might have expected. This dilatation of the urethra for the purpose of examination, and also as a means of curing many of the urethral and bladder diseases, is one of the most important improvements in the management of this class of surgical affections. It is to the urinary organs what stretching the sphincter ani is to the surgery of the rectum.

I have only time to briefly notice urethrocele, and refer you to Dr. Bozeman's article on that subject in the *American Journal of Obstetrics* for February, 1871. In this paper you will find a more extended account of the subject than I can possibly give. The pathology given by Dr. Bozeman is as follows: First the lower portion of the urethra becomes constricted by infiltration of the tissues outside of the urethral mucous membrane. This causes dilatation of the urethra higher up; and at the same time the muscular coats increase in size. The result is, that the central portion of the urethra being distended, settles down, so that in time the urethra, in place of being a straight canal, becomes triangular, the upper portion being the base, and the central and lower portion (that is, midway between the neck of the bladder and the meatus) the apex. At this dependent portion a few drops of urine accumulate, which also increases the distention, and by its decomposition causes inflammation and ulceration. The urethrocele projects down into the introitus vulvæ, in the shape of a tumor, which may be mistaken for cystocele. In time the inflammatory affection of the urethra involves the bladder.

Among the causes mentioned are injuries during labor, over-exertion, excessive coition, congestion, and inflammation of the mucous membrane. The symptoms (after the disease which began the trouble has subsided) are first difficult, and finally painful and frequent urination. The diagnosis can be made from the history and the presence of a tumor in the introitus vulvæ, and the deflected condition of the urethra.

The treatment recommended by Dr. Bozeman is to tap the urethra at the most dependent portion. He proposes to make an opening through which the urine can pass, and leave it open until all inflammation has subsided—say one or many months—and then close it.

Regarding this disease I must say that I have not seen many cases of it, or, if I have, I failed to detect its true nature. One case I remember which corresponded to the history of urethrocele, and was, no doubt, a genuine speci-

men; but I recollect she got well under treatment, which consisted in dilatating the urethra with sounds, and washing it out frequently with a solution of nitrate of silver.

Finally, I will mention fistula of the urethra—not the ordinary opening which comes from injury and is described in text-books along with vesico-vaginal fistula, but blind internal fistula. The history of a case will perhaps answer better than a description. A lady had what appeared to be a cyst in the urethro-vaginal wall. Inflammatory action set in; and the pressure of the knife, used to open it in the vagina, caused an opening into the urethra at the same time. The wound in the vagina healed, but the opening in the urethra remained, and pus and urine accumulated in the sac, and a pretty constant discharge from the urethra continued. In another case of specific urethritis, followed by considerable thickening of the urethral wall, a sac or pocket was formed, which filled with pus and urine, and supplied a discharge which was almost as constant as an acute urethritis.

The treatment in both cases consisted simply of dilatation of the lower portion of the urethra with sounds, and washing out the urethra and sac with borax and water. The patients were also directed to make pressure upon the upper portion of the urethra, after urinating, to force out any urine that might lodge in the fistula or sac. One case recovered, and, as the other did not return, it may have ended in recovery also. In case this method should fail, I think it would be good treatment to make an opening into the sac from the vagina, *i. e.*, make a complete urethro-vaginal fistula, and afterwards close it by the usual operation.—*Cincinnati Med. News.*

HOW TO EXAMINE THE UTERUS.

The following definite directions, given by Dr. Hanks in the *American Journal of Obstetrics*, will, we believe, not be deemed superfluous by a number of readers:—

1. For a thorough examination of the uterus, it is absolutely necessary to provide a good light. I have seen a uterine examination made in a chamber, by a learned physician, with no good resulting, because the room was dark. A Sims or Barnes could have done but little better under similar circumstances.

2. A hard table should be used if possible. If your patient objects to this, let her remain on the bed. The hard table is always preferable, however, and should be placed directly opposite the light. Let the patient lie on the back, head resting on a low pillow, thighs drawn up, legs flexed on thighs, feet resting on the table or bed.

3. If the patient is a young girl, or a nervous unmarried woman, it is best to administer ether.

4. Now proceed at once with the physical examination of the abdomen with the right or left hand, whichever is the best educated, or both.

5. If not satisfied, with the eye also.

6. Next question, with the best educated finger, the condition of the vulva and perineum.

7. Then the vagina. Examine its size, shape, heat, and moisture. Then, passing upward until the finger touches the cervix uteri, consider its position, size, shape, density, and mobility. Passing around the cervix uteri, try and ascertain the position of the body of the uterus; if it is movable, and to what extent.

8. If you are not able to determine, bring to bear another aid, by using the other hand on the abdomen at the same time—the bi-manual method. You may now be able to grasp the uterus, if the patient is a thin woman. If she is stout, you may resort to the uterine sound. If you are an expert, *before* introducing the speculum, otherwise not until afterward. The sound should indicate the position of the uterus, and its shape and size. If the sound is passed with great difficulty, and causes great pain, a stricture or flexion undoubtedly exists.

9. If you are not an expert, you must not be sure of either of these conditions until you have used the speculum. This, if a glass Fergusson, will only reveal the condition of the mucous membrane of the vagina and cervix uteri, and the size and position of the external os. Some form of the short-bladed bivalve specula will serve best, if the patient is a lean woman; if she be stout, a long-bladed speculum will be necessary. If you place the patient on the side, in the Sims' position, you can use his speculum, if you have an assistant; or Thomas' improved speculum, if an assistant is not at hand. Which ever speculum is used, observe this rule in its introduction: *Know positively the exact location of the cervix uteri before attempting to introduce the speculum.* The uterine sound ought now to pass up readily. If an ante flexion is suspected, press the fundus backward with the depressor, or a loop of wire; if a retro flexion, press it upward and forward with the same means.

10. If still uncertain of the conditions, in examination per rectum will be necessary. The finger will detect any disease of that organ, which so often simulates uterine complications. In this way you can judge if a retroversion exists, and of the degree of fixation, and of the irregularity of the posterior wall of the cervix and body of the uterus.

11. Another method remains, if this prove unsatisfactory, that of passing the sound through the urethra; or by dilating it, and using the finger.

REMEDY FOR DANDRUFF.

Don Roy, M.D., in the *Medical Brief* gives the following: R. Chloral hydrat., 10 grains; tr. canthar., 20 drops; glycerinæ, 1 ounce; aquæ, 3 ounces. Mix. Rub from one half to one ounce into the scalp by means of a sponge, and repeat it every morning. A slight burning sensation and reddening of the scalp occurs, disappearing after two minutes. If the hair had fallen off in consequence of the dandruff, it will be renewed in about a month.

POPLITEAL ANEURISM CURED IN TWO HOURS BY THE APPLICATION OF ESMARCH'S BANDAGE.

D. M'H., laborer, æt. 29, was admitted into Manchester Royal Infirmary under the care of Mr. F. A. Heath, Oct. 16. He stated that up to within three weeks of his admission he enjoyed good health. While at his work about that time he experienced a weakness and pain in the calf of his leg, and noticed a lump behind the knee, which throbbled a good deal, and gave him some pain. He had never had syphilis but had been a pretty heavy drinker at times. On admission an aneurism, the size of a small orange, was found occupying the left popliteal space. It pulsated freely, and a distinct bruit could be heard in it. The tibial arteries at the left ankle could not be felt, but were plainly perceptible at the right ankle. The veins on the surface of the left leg were larger than those on the right but there was no œdema of the limb. Heart-sounds perfectly healthy, and area of cardiac dullness normal.

Oct. 17. At 10.15 A. M., after the limb had been elevated to empty it of blood, Esmarch's elastic bandage was carefully applied from the toes upwards, until lower part of the popliteal space was reached. The patient was then directed to stand up in order to allow blood to flow into the aneurism, and the bandage was then lightly passed over it, a layer of cotton-wool intervening. The roller was then applied above the knee to within three inches of Poupart's ligament, where it was secured. Temperature 98.6°; pulse 80. At 11 A.M. the patient was somewhat restless, and complained of great pain in the limb. One-third of a grain morphia given subcutaneously. At 11.15 A.M., temperature 98.6°; pulse 90; Signoroni's tourniquet applied to the femoral artery in Scarpa's triangle, and Esmarch's bandage, having been on exactly one hour, was slowly removed; tumour felt hard, and no pulsation could be perceived in it. The leg and toes looked blue, and felt cold. limb was enveloped in cotton-wool and flannel bandages to maintain the temperature. Pain was relieved on removal of Esmarch's bandage, and the patient appeared very cheerful. At 12.15 P.M. all pressure was taken off for a few moments, exactly two hours after the operation had been commenced. The tumour was quite hard, seemed a little smaller; and no trace of pulsation could be felt in it. A small vessel was noticed pulsating over the aneurism near to the external side; tourniquet re-applied. At 2.15 P.M. pressure was again removed for a short time; no pulsation in the tumour. At 4.14, just six hours after Esmarch's bandage was applied, the tourniquet was entirely removed, and the tumour on being examined was found to be quite hard, and free from pulsation. The patient was not in any pain. The tourniquet was applied lightly over the femoral artery, so as to control, but not to stop, the flow of blood.

18th. 9.30 A.M.: Tumour much smaller and quite hard; no trace of pulsation to be felt in it. Limb quite warm. Three small arteries to be felt pulsating in front and at inner side of knee-joint.

19th. Tourniquet entirely removed. Aneurism hard and getting smaller.

Mr. Heath was led to adopt this method of treatment from the account which appeared in *The Lancet* of the 30th Sept. of the success attending a case of Mr. Wagstaffe's, and his account was followed step by step during the operation. It may fairly be assumed that the aneurism was cured at the end of the second hour, for the tumour was quite hard and free from pulsation at the end of that time.—*Lancet*, Nov. 4, 1876.

WARM WATER INJECTIONS IN THE TREATMENT OF UTERINE HEMORRHAGE.

Extracts from a lecture delivered before the Berliner Gesellschaft für Heilkunde, by Dr. Windelbrand, and published in the *Deutsche Medicinische Wochenschrift*, No. 24, 1876.

If I claim your attention to-day in the discussion of a plan of treatment which seems in direct contradiction to the generally accepted views of the correct course to be adopted by physicians, it will be to direct you to a careful consideration of a course heretofore almost unknown, but which will, in my humble opinion, produce a revolution in the treatment of uterine hemorrhages and the pathological processes producing them. My object will be to induce others to adopt my plan and thus bring into general use an important and valuable means of treatment.

In the first place I wish it distinctly understood that I do not claim any merit of originality, but that this belongs to Dr. Mann of Rhode Island, who made exclusive use of hot water injections in two cases of hemorrhage following abortions and succeeded in both cases in checking it. He claims that these injections not only effectually checked the bleeding but greatly diminished the severity of the pains. I will not enter into any further particulars, but will merely state that the idea struck me as so novel, and at the same time reasonable, that I resolved to resort to it at the first opportunity. This soon offered itself in the case of an abortion to which I was summoned after another physician had in vain applied the tampon, ice injections and compresses, ergot and acids internally, etc. The ovum could be barely reached through the open os; the lower segment of the uterus was very much relaxed and did not show the slightest disposition to contract; the patient was in a state bordering on collapse, and the most decided measures seemed necessary to be taken. I decided, before trying the tampon a second time, to employ the warm injections, which I did by means of an ordinary syringe with an uterine nozzle, the temperature of the water being 38°–39° R. (about 117° F.) Almost at the moment the stream of hot water entered the vagina the cervix began to contract; after 8 or 10 of these injections at intervals of 5–10 minutes, the ovum and its adnexa were forced into the vagina and were readily removed. The case then progressed without further trouble. Since this positive demonstration of the effect of heat on the contractility of the

uterus I have employed it in all subsequent cases of abortions, and indeed in all hemorrhages dependent upon relaxation of the uterus during delivery, whether premature or at term; also in case of inefficient pains and always with excellent results, as I have never yet seen the slightest ill effects follow their use. Very shortly after the first case in which I resorted to the warm injections I was summoned to a woman faint from repeated hemorrhages, with frequent pulse and cold extremities, and on examination found the os slightly dilated, through which could be felt the border of a placenta laterally attached, and the shoulder of the foetus. Even this examination caused profuse bleeding. I attempted to introduce my hand, dilate the os and turn, but was prevented by the rigidity of the neck. Besides, there were scarcely any pains. I now made several injections and had the satisfaction of seeing the uterus take on energetic contractions; after several of those a large amount of amniotic fluid was expelled and the head of the foetus presented. The bleeding had ceased and within a short time the head was delivered in the normal position.

I have likewise stopped the hemorrhage in two other cases of placenta prævia at seven months, and with recurrence to the same plan when necessary have conducted the women safely to full term. *

* * * I have seen the same result of the hot injections on the contractile fibres of the uterus even in cases in which a large portion of the organ was occupied by neoplastic growths, such as carcinomata, and a considerable part of the fibres are rendered useless. Even in such instances they often checked dangerous hemorrhages. * * *

* It is my custom to make the injections with the simple irrigator with my patient occupying the dorsal decubitus. In this way I get a continuous stream. I begin with a temperature of 38° and gradually increase it according to the severity of the case up to 41° R. This can be very readily done as the sensitiveness of the sexual organs is very quickly lessened by heat. * * *

* * * I do not attribute this action to any coagulating effect of the water or heat upon the blood, but to the irritability of the uterus, excited by the hot injections.

THE USE OF ERGOT IN THE TREATMENT OF PURPURA

(*The Practitioner*, NOVEMBER, 1876).

—Dr. L. Duncan Bulkley calls attention to the treatment of purpura by ergot, in an interesting paper. The principal points of which are as follows:

1. The treatment of purpura as advised in books is ineffective and tedious in lighter cases, and insufficient to save life in many of the severe or hemorrhagic cases.

2. Ergot possesses a very decided power in contracting the involuntary muscular fibre, causes divided arteries to contract, acts upon the smaller arteries and capillaries, and has been proved a valuable arrester of hemorrhage in many affections.

3. In purpura the action of ergot is very manifest, causing, when given in sufficient doses, an almost, if not quite, immediate cessation of the cutaneous and other hemorrhages.

4. The most effective method of administration of ergot is by hypodermic injection, and this means renders it peculiarly valuable in purpura hæmorrhagica where there is hæmatemesis, so that its administration by the mouth would be impossible, or in cases where the stomach would not tolerate it.

5. While ergotin, a purified, watery extract, has been advised by many, and has been found to act efficiently in many cases, its action is liable to be uncertain by reason of age or faulty preparation, and after dilution with water it soon becomes inert.

6. Fluid extract of ergot may be administered hypodermically, undiluted, and without local accident, as abscess or inflammation, if care be exercised; and its effect is very prompt and certain.

7. Ergot may be thrown under the skin in any part of the body; the gluteal and shoulder muscles answer well, but the places to be preferred are about the pectoral muscles or at the sides of the chest, about half-way down.

8. Severe cases of purpura require the frequent repetition even of very large doses, whether by the mouth or by hypodermic injection; both methods may be combined.

9. Generally one or two grains of ergotin or from ten to fifteen minims of the fluid extract hypodermically, once or twice a day, are sufficient, but the former may be safely increased to five grains and the latter to twenty or thirty minims, and repeated as often as every hour and a half.

10. Larger doses relatively are required when given by the mouth, and their action, thus given, is more slow.

11. No fear need be entertained of any untoward effect; an ounce of fluid extract by the mouth, and seven grains of ergotin hypodermically, have failed to give rise to any unpleasant symptoms; and from half a drachm to a drachm and a half of the tincture or fluid extract have been continued for several months without producing ergotism.

12. Other preparations of ergot may be employed internally, as the powder, solid extract, wine, or infusion, the dose being proportioned to the effect required or produced.

TREATMENT OF DIABETES MELLITUS.

During the last few years Prof. Ebstein, of Göttingen, has treated a number of cases of diabetes mellitus with carbolic acid, with the result of causing a complete disappearance of the diabetic symptoms in a certain number of the cases, while others were entirely unaffected by the remedy. He accounts for this diversity in therapeutic results by a theory that diabetes is symptomatic of different pathological processes that call for different therapeutic measures. The close relationship between carbolic and salicylic acid then induced him to give the latter a trial. In the first case in which he tried it, it was given in small doses, only from five to eight grs. per

diem, and produced no effect at all; while twenty-five grs. of carbolic acid caused the disappearance of the diabetic symptoms in four days. The Professor, however, now publishes the histories of two cases in which carbolic acid and other therapeutic measures were utterly useless, one of which was cured and the other greatly benefited by salicylate of soda. In the first case, seventy-five grs. of salicylate of soda were given daily in three doses for eleven days. On one day one hundred and fifty grs. were given, but caused vertigo, noises in the head, and fainting fits. In the second case, one hundred and fifty grs. of salicylate of soda was given in four doses on the first day, but it caused so much humming in the ears, that the quantity was reduced on the next day to three doses of thirty-seven grs. daily. Nine days later the quantity was increased to forty-five grs. three times daily, and in fifteen days the urine was reduced to the normal quantity, and the sugar to one-third of the quantity passed before the remedy was used. The quantity of salicylate of soda was subsequently reduced to seventy-five grs. daily, and the patient is still under observation. In this case, restriction to a diabetic diet did not seem to aid the action of the drug, and in the first case the cure took place while the patient was allowed a mixed diet exclusive of potatoes.—*Berliner klin. Wochenschrift* June 12, 1876.

ERGOTIN IN UTERINE FIBROIDS.

Dr. Lombe Atthill, of the Rotunda Hospital, Dublin, writes to the *British Medical Journal*:—

I, in common with all those who practiced the hypodermic injection of ergotin, as recommended by Hildebrandt, have found that this treatment, sooner or later, resulted in the formation of troublesome sores. I think it of some importance to say that, though this is perfectly correct with reference to the cases published by me, and quoted by Dr. Byford in his essay, it is not so with respect to my more recent ones. I have availed myself, since my appointment to the Mastership of this hospital, of the larger opportunity offered me here to carry out this treatment more extensively, and I give the following cases as examples of the results obtained. Case 1, of large intramural fibroid, in a widow, nulliparous, aged thirty-eight; prominent symptoms, distress from weight and size of tumor, menstruation increased but not excessive, returning at intervals of twenty-one days; with an intra-menstrual discharge of blood, moderate in quantity, lasting for three days; thirty injections, practiced at intervals of two and three days. Result: total disappearance of the intra-menstrual discharge, slight prolongation of the intra-menstrual period, hardening and apparently slight diminution of the bulk of tumor, no pain caused by injection or irritation following it. Case 2. Single woman aged forty-five, rendered exsanguine by profuse menorrhagia, accompanied by excessive pain, and lasting fifteen days and upward, intra-

menstrual period of not more than from seven to ten days; of late, in fact, seldom free from a red discharge; large intramural fibroid filling up plevus, and reaching to within an inch of umbilicus. Upward of sixty injections of ergotin; admitted January 6th. Result: March 10th, flow diminished in quantity and lasting for six days, intra-menstrual period prolonged to twenty-one days; April 1st, menstruation reappeared this day, lasted but two days; May 21st, menstruated to-day, flow lasted four days. Marked as the improvement was as regards the check put on the loss of blood, her condition in other respects was not satisfactory; her sufferings, always great, were aggravated, the injection being always followed by severe pain, referred to the tumor, necessitating the constant use of morphia; she seldom could leave her bed; and I finally abandoned the treatment, and am now endeavoring to enucleate the tumor. I hope, at a future time, to publish the case *in extenso*. At present, I wish merely to point out the fact that the injection of ergotin, in either of the two cases I have detailed, was not followed by the formation of sores; nor has it been in several others in which it has been recently practiced for a shorter time by me. The only explanation I can give of the greater success in my later cases is this, that whereas I formerly added a small quantity of glycerine to the solution of ergotin, as recommended by Hildebrandt, I now employ a solution of one part of the extractum ergotæ liquidum (*British Pharmacopœia*) in two of water, injecting 15 or 20 minims of this each time. I always insert the needle into the gluteus muscle, making it penetrate to the depth of more than an inch.

PERNICIOUS ANÆMIA.

BY W. A. ROTHACKER.

Pernicious Anæmia was first described as a distinct disease by Biermer.

Biermer's cases, which were mostly women, showed, besides a high grade of anæmia, the following appearances:

In nearly all of the cases there were retinal hemorrhages; more rarely petechiæ and capillary hemorrhages were found in the brain and the meninges. The disease was, with the exception of one case, fatal. The post mortems revealed fatty degeneration of the heart and of the intima of the arteries and capillaries.

Quincke observed ten cases of this disease, *i. e.*, four men and five women between the ages of 25 and 59 years, and one girl aged 11. In all of these there was a waxy hue of the skin and mucous membranes, and puffiness of the face. In several of the cases there were marked dropsical manifestations. All of the patients were very weak and frail, so that they were obliged to remain in bed. The pulse was frequent, small and soft, and a loud anæmic murmur could be heard at the base of the heart, particular-

ly over the pulmonary artery. The heart was often found to be much dilated, and sometimes there was found fatty degenerations. The liver in several cases was very fatty. Some of the patients were troubled with repeated bleeding from the nose, others had petechiæ on the skin. Hemorrhages into the retina were constantly found without any existing disturbances of vision. The temperature was either normal, or it followed the line of a mild remittent fever; seldom running higher than 102·2°. The spleen, lymphatics and spinal cord presented no changes. The disease was slow in its development, but continuous in its progress. Its average duration was from one-third to one year, and death was the result of exhaustion, and seldom of any intercurrent affection. Quincke only observed two cases which recovered. In pregnant women the prognosis is absolutely unfavorable, as in all cases the patients died a few hours after a resulting abortion. In the early stages of the disease, patients very much resemble in general appearance those affected with Bright's disease in whom there is a beginning contraction of the kidneys. The albuminuria is only transient, and there is never hypertrophy of the left ventricle. Sometimes the patients, from their appearance, will bring to mind cases of ulcer or cancer of the stomach, or of typhus. The ophthalmoscopic appearances, *i. e.*, retinal hemorrhages and sometimes the retinitis of Bright's disease, are pretty constant.

With regard to the etiology of the disease, it may be remarked, that a number of cases were observed in Switzerland; that many of the women were pregnant and that the majority of the patients were in poor circumstances. The total amount of blood in these patients was always diminished. The blood was light in color, thin in consistency, and flowed with difficulty. Microscopic examination revealed marked decrease in the red corpuscles, with considerable variation in their size, which latter condition was due to imperfect development of some of the corpuscles, and partial destruction of others. Repeated examination of the blood showed great destruction of the red and white corpuscles, with a defective reproduction of the same. This form of anæmia may follow the most various forms of disease. Its treatment is like that of ordinary anæmia. Transfusion has as yet brought no benefit.—*Quincke Wiener Med. Woch.*, No. 35.

TREATMENT OF CHRONIC ECZEMA.

In reply to a request on this subject, from a correspondent in the journal for July 15th, I think a few recent cases, illustrating the curative effect of carbolised oil in this painful disease, are well worth recording. I have used it in a great many cases with complete success. I may further add, that, although bathing in plain water frequently increases the irritation of the diseased parts, I have always found that bran-water (prepared by pouring boiling water on bran, and allowing it to cool) immediately relieves the smarting. Case 1.—H. B.,

aged 50, plasterer and moulder, a strong, healthy man, rather intemperate, suffered from eczema of the phalanges of both hands off and on for several years. He came under my notice in January, 1875, when his hands had been bad for seven months, and he was quite unable to work. Both hands were very irritable, covered with deep fissures, and weeping freely. I ordered him to bathe his hands twice a day in bran-water, and apply lotio plumbi constantly, and to take a saline mixture with five minims of liquor arsenicalis three times daily. In a few days, the irritation had all subsided, and he was then ordered to dress the fingers twice daily with lint soaked in carbolised oil (thirty minims of carbolic acid to one ounce of olive oil). This treatment was continued for six weeks, when he was dismissed cured. He came under my care in June, 1876, with a slight attack of eczema of the right leg, which speedily gave way to treatment; the hands had remained perfectly free from the complaint. Case 2.—J. S., aged 42, a baker and confectioner, very temperate man, always had good health, with the exception of an occasional attack of cracked fingers. He now suffered from severe eczema of all the phalanges of the left hand, which had been on him for several months. He was ordered to take three minims of liquor arsenicalis in half a wineglassful of water after each meal, to bathe the hands frequently in bran-water, and rub the fingers well with carbolised oil night and morning. He was completely cured in three weeks. Case 3.—Mrs. W., aged 36, at present under treatment, is the mother of several children, of temperate habits, rather inclined to corpulency, but otherwise enjoys good health. She has had eczema of all the phalanges of both hands for more than two months. The fingers are very red and swollen, with numerous fissures, which are extremely painful, and discharge watery fluid. She was ordered to bathe the hands frequently with bran-water, and then cover them with lint constantly moistened with lotio plumbi. The inflammation quickly subsided, and the usual carbolised oil was substituted for a lotion. She is taking internally a saline aperient mixture, and is rapidly getting well.

HARRY CROOKSHANK, M.R.C.S., etc.,
Lansdowne Crescent.

—*British Medical Journal*, Sept. 2, 1876.

ON THE DIAGNOSIS OF PROGRESSIVE PERNICIOUS ANÆMIA.

Professor Hermann Eichorst, M.D., of Jena says in the *Centralblatt für die Medicinischen Wissenschaften*:—

In No. 100 of the clinical essays in Volkmann's collection, Professor Quincke, of Berne, treats of this disease. For more than two years I have busied myself with this disease, which is of very rare occurrence in North Germany.

The result of my investigations leads to the opinion that the collection of symptoms which

pass under the above name may be diagnosed with absolute certainty in its earlier stages. But clinical appearances do not furnish the material for a diagnosis; one must look for anatomical changes in the blood; in short, one may denote the affection as a disease of the blood-corpuscles, which is as easily recognized as leucæmia. The changes alluded to were not found missing in one of my seven cases, and I frequently demonstrated them to my colleagues.

While a portion of the red blood-corpuscles possess a normal size, and are only remarkable through paleness and a reduced disposition to the nummular arrangement in aggregations, one finds among them others which at once strike the eye by their smallness. These latter often attain scarcely the fourth part of the diameter of a perfectly developed corpuscle; they are more deeply saturated with color; and when one rolls them beneath the cover glass it will be observed that on a profile view the biconcave appearance is more or less completely lost; their diminution in size even goes so far as to make many of them look like little globules of fat tinged with red.

Many hundred examinations of the blood were made in the cases of healthy individuals and in those laboring under manifold diseases, more particularly in anæmic and cachectic conditions but without the discovery of changes similar to those above described. If one has the opportunity to examine the blood in the earlier and the progressive stages of the disease, it will become evident that the worse the disease grows the greater will be the increase in number of the before-mentioned foreign elements; and I have collected the data in one case where the relatively intact blood-corpuscles, toward the end of life, were equal in quantity to those which were represented by the diminutive reddish drops. In all the observations the white corpuscles were found remarkably sparse; and very small collections of the well-known protoplasmic masses were found, which is very often the case in the blood of healthy individuals also.

I believe myself justified in regarding the described discovery as one enabling us to diagnose progressive pernicious anæmia.

THE TREATMENT OF RANULA.

The Paris correspondent of the *British Medical Journal* writes:—

Ranula is admitted by all surgeons to be a most troublesome, and in many cases, a most intractable affection. It is sometimes so little amenable to treatment, that some surgeons and among them the celebrated Dupuytren, contrived different means by which to keep open a fistulous orifice in the tumor, in order to empty the contents of the latter in the mouth. Jobert de Lamballe endeavored to effect the same object by in-

verting a portion of the internal surface of the ranula, and uniting it by a suture with the mucous membrane surrounding the orifice. M. Panas, of the Lariboisière Hospital, finding these methods of treatment unsatisfactory, and after having given a fair trial to the different remedies in vogue for the cure of this affection with equal unsuccess, has lately resorted to the practice of injecting these tumors with a solution (one to ten parts) of the chloride of zinc, the results of which are most encouraging. M. Panas injects into the tumor from three or four to eight or ten drops of this solution which also varies in strength according to the age of the patient, and this he does with a hypodermic syringe.

On the same subject, Mr. T. H. Morton, of Sheffield add:—

I might observe, without entering into the morbid conditions leading to obstruction of a sublingual gland or duct, that, practically, the surgeon's intention is to make a permanent opening in the sac, one which will allow the saliva continuous and natural exit into the mouth. It occurred to me, some years ago, that the use of a metallic seton acting, to some extent as a drainage-tube, would attain this object; and, as two cases (both children) came under my notice, I tried the following operation. An ordinary suture-needle, carrying medium-sized silver wire, having been passed directly through the sac-like tumor from one side to the other, the ends of the wire were brought forward, twisted together, and cut off, leaving a small ring of metal half within and half externally. The wire was allowed to remain three weeks, then cut and withdrawn. It caused no irritation or impediment, and a patent orifice remained after removal. Both cases were permanently cured. The ordinary seton, made of silk or hemp, necessarily sets up inflammation, and may induce subsequent closure or fistulous aperture. Injection of caustic fluids, as chloride of zinc in ranula, is open to objection, as destruction of tissue is not desirable, at least in simple cases of obstruction. The plan I suggest is worthy of extensive trial, as it promises to supersede those hitherto adopted.

THE TREATMENT OF BURNS.

It is always useful to have at one's fingers ends the best treatment for such common and painful emergencies as burns and scalds, and, indeed, such knowledge cannot be too widely diffused. The summary given by Mr. Holmes, in his recent *Manual of Surgery*, is very concise and complete, and embodies large experience. He says:—

At the time of the accident, the main indications are to exclude the air from the burned surface, to allay pain by opiates, and to give stimulants in such quantities as may be necessary. The applications which are in use for

burns are too numerous to mention, and the choice of one or other of them will depend in a great measure on the depth of the burn. A mere superficial scorch is best treated by some warm solution applied on a thick rag and kept constantly moist. Goulard-water with laudanum is perhaps as grateful as anything. Painting the surface with ink soon relieves the pain of a small superficial burn, or covering it with whitewash or some other similar substance, which will crust over it and completely exclude the air from it. Common flour thickly dredged on the part is a very good and handy application. But such crusts should not be applied over burned surfaces of the second degree, since their removal would soon become necessary, and this would drag off the epidermis. The bullæ should be pricked, the epidermis gently smoothed down, and some simple ointment put next the skin, or some oily substance which will not stick when it is necessary to change it. A very favorite application to these burns and to others of greater depth is the Carron oil, made by mixing lime-water and linseed oil, in equal parts, and deriving its name from its having come into extensive use at the great Carron Foundry in the numerous burns occurring there. Oil of turpentine is a very good application to those in which the surface of the skin is quite destroyed. But for the first few days I doubt whether anything is better than simply swathing the part in thick layers of cotton-wool, which is prevented from sticking to the burned surface by some simple ointment (cerat. calaminæ is generally used) spread on thin soft linen or cambric, and covering the whole burned surface. When, after a few days, the discharge becomes foul, this dressing should be changed for some deodorizing or antiseptic oily application, or the latter may be used from the first; but all the antiseptics I have yet seen used have been stimulating, and, for the first few days, it is desirable, I think, to avoid any local stimulation. The carbolized oil answers every indication better than any other substance which I know of, but it should not be used too strong; for it may both prove too stimulating, and thus increase the discharge, and it may be absorbed, producing a black condition of the urine, and other symptoms of incipient poisoning. It is well, then, to begin with a very weak solution (about 1 to 12), and if this does not correct the fetor its strength may be gradually increased, or a stronger solution of carbolic acid may be placed over the dressings. If carbolic acid is not tolerated, some preparation of benzoine, or Condy's solution, or the lot. sodæ chlorinatæ may be applied either directly to the burned surface or over the dressings.

TREATMENT OF SPINA BIFIDA BY ELASTIC LIGATURE.

At the meeting of the Société de Chirurgie on May 3, 1876, M. Monchet communicated two cases of spina bifida treated by elastic ligature. In the first case the tumor was at the level of the sacrum. It was first emptied by puncture, and an elastic ligature was then applied at the base of the sac. By the 21st day the child was cured. In the second case the tumor occupied the lumbar region, and the elastic ligature was applied immediately after birth without any previous puncture. The child died on the eighth day from intestinal troubles, but without any symptoms of paralysis or convulsion. Six cases in all have been recorded of this mode of treatment, out of which there are three successes, one failure, and two deaths.—*Obstetrical Jour. of Great Britain.*

FETID FEET.

A very obstinate case of this complaint in a workman is reported in the *Bull de Thér.* by Dr. Ortega. In the manufactory in which he worked he was avoided by his fellow-workmen, and when he entered a room the window would be opened. He had consulted several physicians, but without success. The epidermis of the sole of the foot was white and macerated, and there were little ulcerations at the clefts of the toes and around the nails. M. Ortega advised him to apply compresses soaked with a solution of chloral, which had the effect of rapidly destroying the smell and curing the ulcerations.—*Medical Brief.*

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TO OUR SUBSCRIBERS.

Will our subscribers have the kindness to attend to the accounts which we enclose. We have payments to make every month, and we need the money.

MEDICAL LEGISLATION.

Those of our readers who have, for the past year or more, followed closely our editorial columns will have noticed that a breeze was

blowing in the Medical Politics of the Province of Quebec. Among a certain number of the profession there was a feeling that the College of Physicians and Surgeons of Lower Canada—the legal custodian of the Profession's honor—was not wide enough awake; that much of the power which they in former days exercised was, from change of circumstances, obsolete, and that a radical alteration was necessary. To those who held these views we must at least give the credit of earnestness, for they proceeded to act upon their convictions, and it was with not little surprise that the College, and we may add the majority of the profession, a year ago, learned that legislation was being attempted, and that a Bill had actually been introduced by Mr. Chapleau, at their instigation, into the Legislature of the Province of Quebec, but which was not pushed beyond its second reading. While we have in the past not hesitated to say we considered the conduct of the prompters of Mr. Chapleau's Bill as not justifiable, yet it was not without some good result. The College had been somewhat tardy, through its Committee appointed at the Tri-Annual Meeting, held at Sherbrooke in 1874, in deciding what changes were needful; but the action of those who introduced this Bill, made them realize that work and not procrastination was necessary. After much discussion, at the meeting of the College of Physicians and Surgeons of Lower Canada, which was held in Quebec in October last, a Bill was decided upon, and at the opening of the present session of the Quebec Legislature, it was introduced by Mr. Loranger. Its principal feature was that the various Universities in this Province should give up the right which they possess under their Royal charter, to have the license of the College issue to their graduates without further examination. It was proposed to establish a central examining board, appointed by the College, before whom every graduate must appear and be examined before getting his license. To this proposition we believe McGill University, Bishop's University, and Victoria College assented,—certain conditions, however, being attached, as far as the first two Universities were concerned, and that was that the constitution of the College as regards members should remain as it was, viz.: licentiates, eligible after four years for election as members, and a fee of ten dollars attached. The Bill of

course had other good points, which space does not permit us to refer to. It was widely circulated, and was, so far as our experience went, generally considered an excellent Bill. The Medico-Chirurgical Society of Montreal, embracing, with one or two exceptions, every English practitioner in the city of Montreal, discussed it clause by clause, and recommended it, and a petition, signed by over two hundred licentiates of the College, embracing an almost equal number of both nationalities, in its favor was presented to the House. With such a backing, we think the Legislature would have been justified in accepting it. However, the College Bill and the Bill introduced by Mr. Chapleau last session were referred by the House to a special committee of its medical members, and on Thursday, the 14th December, those who had actively worked in connection with them appeared before the Committee: McGill University was represented by Dr. R. P. Howard; Bishop's University, by Dr. F. W. Campbell; Laval University, by its Director, the Rev. Mr. Hamel; Victoria College, by Dr. Rottot; The College of Physicians and Surgeons of Lower Canada, by its president, Dr. R. H. Russell, and its registrar, Dr. Fenwick; Drs. Lachapelle and Dagenais appeared on behalf of the Bill introduced by Mr. Chapleau; while the Sorel Medical Society was represented by Dr. Bruneau, and, not satisfied with either Bill, drafted one of its own, which was submitted to the Committee. The whole day was taken up by the above gentlemen in addressing the Committee, but the University of Laval declined to allow her *alumni* to be re-examined for the College license, and it then became evident that the main point in the Bill of the College, viz.: the Central Examining Board, would have to be abandoned. Laval expressed her willingness, however, to submit to a visitorial board being present at her examinations, this being what was done in England. It was a fact evident to all who were present that, to obtain amended Legislation, compromises had to be made on every side. The Committee of the House, therefore, referred the three Bills before them to a special Committee, composed as follows:—Dr. Russell of Quebec and Dr. Fenwick of Montreal representing the C. of P. and S. of L. C., Dr. Howard of McGill University, and Dr. F. W. Campbell of Bishop's University; Dr. Larue,

of Laval University, Dr. Rottot of Victoria College and Dr. Dagenais, representing the promoters of Mr. Chapleaus bill, and Dr. Marsden, representing the medical profession of the City of Quebec. To this Committee the three Bills were referred, with instructions to draft a Bill acceptable to all. To this—no easy task—the Committee set to work at 5 o'clock on Thursday evening, and they continued in session till they completed their labors, which was shortly after 2 o'clock on Friday morning. On Friday this Bill was submitted to the special Committee of the House and adopted, clause by clause; and on Friday, the 22nd of December, it passed its third reading in the Legislative Assembly, two alterations being made in the House. We had hoped to have been able to lay this important document in full before our readers in this number, in fact, delayed our issue one week for it, but it has been impossible to obtain in Quebec a copy of the Bill, we having been assured that only two or three English copies were printed, and that these were seized upon before they reached the House. We will, however, publish it next month. In the meantime we may say that the Bill is an extremely liberal one, inasmuch as it constitutes every legally qualified member of the profession at present practising in this Province a member of the College. For this they have to pay the sum of two dollars a year. Members are, however, not eligible for election as governors till they have been members for four years. The old title of licentiate is done away with, and the title of member substituted. Every practitioner in the Province is obliged to register within one year after the passing of the Act, and pay a fee of one dollar, and for every year which he allows to pass, and neglects this duty, he incurs a penalty of five dollars. The number of governors is increased from thirty-six to forty, the extra four being given to the District of Montreal. Each of the Universities and schools at present in existence in the Province, viz., McGill, Laval, Bishop's and Victoria, are entitled to two governors, and their election is not by the members, but by the Universities or Colleges which they will represent. The course of study which students shall follow is prescribed by this Act, instead of being, as formerly, a by-law of the College. It, however, remains as before, with the addition that a three months course of Hygiene is com-

pulsory, and that each student has to take a course of twenty-five demonstrations on Microscopic Anatomy, Physiology and Pathology. Hospital attendance is increased from one year to one year and a half. *Every* student has to pass his Matriculation examination before the Board on commencing the study, and to conduct this examination four examiners engaged in general education are to be named by the Board, two residing in Montreal and two in Quebec. The period of study, as before, extends over four years, and not less than three sessions must be at a University or College recognized by the Board. This clause will prevent any further graduation of students after two consecutive sessions at College. Of the three sessions at College, the first *must* be taken on commencing the study. Power is given the Board to frame tariffs for cities, towns and country, and no one can collect in any Court of Law who is not registered under this act, and paid his annual subscription of two dollars to the Board. This is a most important clause, and we would specially draw attention to it. The Board has power to appoint two "Assessors" for each University or School in the Province. The duty of the "assessors" shall be to attend the examinations, and report whether they are satisfactorily conducted or not. The Board has power to refuse registration of its degree to any University reported unfavorably upon until such time as the examinations are amended. These assessors are to be appointed outside of the Board of Governors, that is from among the outside profession. No certificate required by any Act now in force from any physician will be valid unless he be registered under this Act. The penal clauses of the Bill are very great improvements upon those of the former act. We cannot close this article without recording our estimation of the very great assistance rendered by the Medical members of the House. To Dr. Church, Provincial Treasurer thanks are especially due, as they likewise are to Drs. Cameron, Duhamel, Rinfret and Laberge.

PERSONAL.

Dr. J. E. Kennedy, professor of *Materia Medica* in Trinity College Medical school, has been named an attending physician to the Toronto General Hospital.

The following appointments have been made in the School of Medicine and Surgery of Montreal (affiliated to Victoria College). Dr. G. O. Beaudry, pro-sector to the chair of anatomy; Dr. A. Lamarche, demonstrator of anatomy and curator of the museum; Dr. Lachapelle, lecturer on hygiene.

Dr. William F. Scott (M.D., McGill College, 1876) of Hull, Que., passed his final examination, and was admitted a member of the Royal College of Surgeons of England, on the 15th of November last.

CIVIC SMALL-POX HOSPITAL STATISTICS.

We do not think that a more telling argument in favor of vaccination could be found, than the following statistics of the death rate of the Civic Small-Pox Hospital, from November 7th, 1874, to Nov. 1st, 1876:—

Protestant Hospital.—Total number received, 168. Died, 34. = 20.23 per cent. There were 54 unvaccinated, and of these 25 died: = 46.29 per cent. There were 114 vaccinated, of these 9 died: = 7.89 per cent.

Catholic Hospital.—Total number received 396. Died 127: = 32.07 per cent. There were 165 unvaccinated, of these 89 died: = 53.93 per cent. There were 231 vaccinated, of these 38 died: = 16.45 per cent.

In both Hospitals 564 Received. Died, 161 = 28.54 per cent.

Unvaccinated, received 219. Died, 117: = 53.42 per cent.

Vaccinated, received 345. Died 47 = 13.62 per cent.

We would suggest that, as many who have been vaccinated, reject re-vaccination as useless, it would be advisable in future to keep a record of the cases of small-pox which occur among the re-vaccinated. We have no doubt but that the result would prove the all but absolute safety which re-vaccination gives.

SPENCER WELLS' METHOD OF OPERATING.

A correspondent in the *Boston Medical and Surgical Journal* thus describes the method of the great ovariologist as witnessed during the seven hundred and ninety-fifth operation:

"1. Those invited to attend were requested to sign a certificate that they had not been pre-

sent within seven days at a post-mortem examination, visited a dissecting-room, or treated a case of contagious disease.

"2. They were then, punctually to the moment appointed, taken to an upper chamber, with bright, open exposure to the southwest, where Mr. Wells stood in readiness for his patient, who was already anaesthetized.

"3. Bichloride of methylene was the agent administered; or rather air charged with methylene by means of a caoutchouc pump.

"4. The lower extremities were confined by a band across them; the upper ones by a strap to each wrist, the arm being brought down beneath the table and fastened to one of its supports.

"5. The abdomen was covered by a thin rubber sheet, with a circular opening adapted to the possible length of the incision. Beneath the table, to catch the fluid contents of the cyst, or any thing which might drip, was an ordinary metallic hip-bath tub. Under the edge of the table, fastened so as to be within immediate reach of the operator, hung Mr. Wells' large spring-trocar, with a long curved arm, to which was attached a rubber tube of great caliber communicating with the tub beneath.

"6. None of the bystanders were permitted to examine or otherwise touch the patient.

"7. The incision was short, low down, occupying but a portion of the umbilico-pubic interval, and was completed upon a director of peculiar form, broad toward its rounded extremity. There were extensive adhesions, which were broken down by the hand with tolerable ease. Moderate hemorrhage occurred from their site, and from vessels in the line of incision. The cyst was multilocular, one of its cells containing a large amount of turbid fluid. Through the trocar-opening, sufficiently enlarged, Mr. Wells passed his hand and broke down such of the adjoining septa as would thus yield. The mass having then been readily delivered, a stout, slightly curved steel clamp was attached to the pedicle, and on severing this the first stage of the operation was completed in ten minutes from the first stroke of the knife.

"8. The other ovary, though still small, proving cystic, was also removed, the base being transfixed by a double silk thread tied on each side.

"9. All coagula having been carefully removed from the peritoneal surface and pelvic cavity, the clamp was adjusted crosswise externally, and the wound was closed by seven stitches, the pedicle emerging between the last and the last but one. These sutures, like the ligature already described, were of Chinese silk, uncarbonized. They were passed through both the integument and the peritoneum, without, however, taking up the whole thickness of the abdominal wall, and during their tying the loose pouch of the abdomen was bunched up, as it were, by the hand of an assistant. The threads were provided with a needle at each extremity, the second of which was held by the operator's lips while the first was being passed, thus preventing twisting and other entanglement, and permitting greater speed.

"10. The wound having been closed, bits of lymph were carefully placed under the clamp and between the sutures; the extremity of the pedicle outside the clamp was touched with solid perchloride of iron; the abdomen was covered with cotton-wool, over which were strapped broad bands of adhesive plaster; a binder of flannel was placed outside this, and the entire operation was completed in just half an hour from its commencement.

"Nothing could have exceeded the adroitness and celerity yet absolute thoroughness and perfect neatness of the whole procedure. There were two female nurses and two assistant surgeons, besides the gentleman in charge of the anæsthetic. They were all constantly occupied, and each knowing exactly what to do, at what moment, and how, never came for a moment into the others' way; so that there were six busy pairs of hands, every one at its especial work. The operation, from beginning to end, was as if done by the most perfect yet sentient mechanism, and was an apt illustration of the consummate skill that only such unequalled practical experience as that of Mr. Wells could produce."

HYGIENE OF THE HAIR.

Bazin, the distinguished surgeon of the St. Louis Hospital, in an article for the *Dictionnaire des Sciences Médicales*, says that under ordinary circumstances the care required for the head should be directed merely to favoring the removal of the dust and deposit upon the

hairy scalp. In very young infants the brush and comb should give place to simple acetic or alkaline lotions or the inunction of some fatty substance, such as cold cream or the oil of sweet almonds. The practice of washing the scalp with warm or cold water is essentially bad, because it renders the hair dry, brittle, and lusterless. In women the more or less complicated methods of dressing the head which prevail necessitate the squeezing, dragging, and twisting of the hairs in every direction—processes extremely unfavorable for their nutrition. Ladies should be taught that hairs, though insensible to pain, are not inert and lifeless, and that the most hygienic of all coiffures is that which leaves to the hair the greatest liberty and aëration and the most frequent repose. The habit of wearing the hair long in men is bad, because they rarely spend the requisite time in cleansing it. The practice of clipping it close to the head is detestable, and absolutely contrary to the purpose for which it was designed. Cutting the hair short, in order to favor its growth, is the result of a prejudice which nothing can justify, while periodic hair-cutting within reasonable limits is not injurious. Contrary to the generally received opinion, Bazin concludes that the finest heads of hair are those which the scissors have never touched. The habit of "refreshing" the hair—that is, of cutting away from time to time a small portion—may be indicated when the growth is thin, wasted, or meager. The use of the razor should *always* be avoided, even when it is required to cut the hair very short as in convalescence from grave disorders. Epilation, when employed for the purpose of removing white hairs, only hastens the supervention of canities. The employment of cosmetics, instead of being allowed as of common usage, should be strictly confined to certain cases. Those who when in perfect health have naturally greasy hair should be advised to use very weak alkaline lotions. Those, on the contrary—who have dry and harsh hair may use oily applications. Without expressing much confidence in the measure designed to prevent the loss of hair, the author concludes that sometimes the effort should be made. Hair-dyes are of two kinds. The first (galls, infusion of nuxvomica, and pomegranate) is almost inoffensive, but gives uncertain and unstable results. The second—whose basis is generally lime, nitrate

of silver, lead, or sulphate of iron—is successful in the result but dangerous for employment.

CAUSES OF PUTREFACTION AND FERMENTATION.

The *Popular Science Monthly* says:—A year or two ago, Dr. J. Dougall, of Glasgow, at the Social Science Congress, held in that city, announced, as the result of investigations made by himself, that the presence of an alkali determines putrefaction in organic matter, while the presence of an acid determines fermentative changes. The same line of inquiry has been taken up since by Dr. John Day, of Victoria, Australia, who finds in Dougall's discovery an explanation of the presence in hospitals of septic poisons, giving rise to pyæmia, erysipelas, and puerperal fever. The *Sanitary Journal*, of Toronto, has a paper by Dr. Day upon this subject, the purport of which may be briefly stated as follows: Hospitals, as usually constructed, have alkaline ceilings, alkaline walls, alkaline floors (owing to the use of soap in cleansing them). Experience has shown that pyæmia is of extremely infrequent occurrence in temporary hospitals consisting of rough wooden sheds. The incessant generation of peroxide of hydrogen by the turpentine of the wood doubtless prevents putrefactive changes, but, as turpentine always gives an acid reaction, this circumstance must greatly increase the disinfecting power of the peroxide, by determining the fermentative instead of the putrefactive decomposition of the pus-cells and other organic matter given off from the patient. Dr. Day proposes the following method of counteracting the evils of hospital life: The boards of the floor he would first cover with a coat consisting of equal parts of gasoline and boiled linseed-oil, to which is added a little benzoic acid. When dry, the surface is polished with a paste of beeswax, turpentine, and benzoic acid. Boards so prepared are, in his opinion, rendered permanently disinfectant. The walls and ceilings might be rubbed smooth, and coated with a varnish of paraffine or oil of turpentine; or, better still, they might be coated with silicate paint, then rubbed down and varnished. For the purpose of keeping the air pure, and destroying the pus-cells floating in it, he recommends, in addition to ventilation, the use of certain volatile substances, such as gasoline, benzine, and eucalyptus-oil. The furniture should be occasionally

brushed over with either gasoline or benzine, in which a little benzoic acid has been dissolved.

ARTIFICIAL TOBACCO

According to the *Scientific American*, artificial tobacco leaves are now being produced in New York for the manufacture of Havana cigars. The material used is a kind of brown wrapping-paper, made especially for the purpose. This paper is saturated with the juice pressed from tobacco stems and other offal, and then rolled through a machine which gives them the appearance of the tobacco leaf, with the peculiar spots printed on them as on calico. The paper thus prepared is especially adapted for the wrappers around the cigars, and for that purpose is even preferred by the Havana cigar makers to the genuine leaf, and they import it largely from New York. According to our authority as much as 30,000 reams of this artificial tobacco leaf have been occasionally exported. It is further stated that this tobacco-flavoured straw paper makes also a filling superior to the genuine leaf, and that the paper leaves no residuum other than a pure light grey or nearly white ash, just like that of the best quality of tobacco.

BI-CARBONATE OF SODA IN SUPPRESSION OF URINE.

Dr. Wilson of Clay Cross writes, in the *British Medical Journal* of the 22nd of July last, that he has applied the following plan with marked success in the treatment of suppression of urine. He says:—"I allude to cases of complete suppression, with general dropsy, coma and convulsions. Here an enema of half an ounce of acetate of potash in from one to two quarts of warm water, poultices (linseed or digitalis) to the loins, cold to the head and sinapisms to the leg. Where there is much irritability of stomach in acute desquamative nephritis, this alkaline enema is a valuable adjunct to treatment."

The Philadelphia correspondent of the *Boston Medical Journal* says the attendance at the Jefferson and the University Medical Schools in that city is larger than ever before. He accounts for the increase in spite of the hard times, by saying that most likely they reason thus: "There is nothing else to do, let's be doctors." He says, "you may have heard the story of Sir Walter Scott's colloquy with a grave, sagacious-looking doctor, attired in black,

for whom, in a small English town, Scott had sent on behalf of his sick servant. In the doctor, Scott, to his amazement, recognized a Scottish blacksmith, who had formerly practised as a veterinary operator. "How in the world" exclaimed Sir Walter, "came you here? Can it be possible this is John Lundie?" "In truth it is, your honor, just a' thats for him," "well, let us hear, you were a horse doctor before; now it seems you are a man doctor, how do you get on?" "Oh, just extraordinar' well, for your honor maun ken that my practice is vera sure and orthodox. I depend entirely on twa simples." "And what may their names be? Perhaps it's a secret." "I'll tell your honor" (in a low voice) "my twa simples are just laudamy and calamy;" "simples with a vengeance!" replied Sir Walter, "but, John, do you never happen to kill any of your patients?" "Kill, ou ay, may be sae, whiles they dee, and whiles no; but it's will o' Providence. Onyho, your honor, it will be lang before it maks up for Flodden!"

DROPSICAL EFFUSIONS.

Dr. Charles Burr, of Carbondale, Pa., (*Philadelphia Medical and Surgical Reporter*) tells us, in the *Pennsylvania State Transactions*, that he used to feel quite uncertain when called to a case of dropsy, but now he "can smile and promise a speedy cure." The reason of this change is his adopting in all such cases the following prescription:—

℞ Infus. digitalis, f ℥ iv
Potassæ acetatis, ʒ ss. M.

Dose—For an adult a tablespoonful, for a child a teaspoonful, every two hours.

If this prescription will exercise generally so happy an effect on physician and patients, our readers will thank us for reproducing it. We are very doubtful, however, of its universal efficacy.

LONGEVITY.

A remarkable case of longevity is reported in *Virchow's Archiv*, by Dr. OrNSTEIN of Athens. The man, George Stravarides, died in Smyrna, at the age of 132 years. Although this Methuselah had always lived an irregular life, and had consumed an average of more than a hundred drachms of brandy daily, he retained full possession of all his five senses, as also a complete set of teeth, up to the moment of his death. He also continued to the last to attend to the duties of his avocation—a

baker. This man was born in 1743, in the reign of Mahmud I, and lived during the reigns of nine sultans.

—The Russian army, on January 1, 1876, had 2102 surgeons, 250 apothecaries, 6887 assistant surgeons, and 173 veterinary surgeons. This gives one surgeon for every 407 men, one apothecary for every 3454 men, and one assistant surgeon for every 161 men.

MEDICAL ITEMS.

The death of Dr. Arthur Jacobs of Dublin is announced. He was born in 1790. His memory will be kept alive by the "membrana Jacobi" of the eye. He was the founder and original editor of the *Dublin Medical Press and Circular*.

Our contemporary, the *Pacific Medical and Surgical Journal*, occasionally gives its readers a *feu d'esprit* at the expense of the homœopaths, who, however, no doubt enjoy them as much as their "allopathic brethren." The following is the latest: A homœopathic doctor of Cairo, Ill., writes to the homœopathic journal of Chicago that he has been suffering for twelve years with neuralgic pains, resulting from a fall from a horse. He says: "I have used *Aconite* low, *Ars.* high and low, *Arnica* high and low, *Bry.* high and low, *Merc. Viv.* and *Bin-iod.* low, *Kali-hid.* low, and *Canth.* high and low, and nothing but counter irritation and rest ever gave me any relief. Will any of my professional brethren suggest a remedy?"—We will suggest a remedy on the principle of *similia similibus*. Take a strong bottle filled with water and let it fall from a horse as nearly as possible in the way you yourself fell. Take one drop of the water thus medicated, potentize it low, and smell it. If that should not cure you try it high.

MARRIAGES.

At Quebec, on the 31st October, at the St. Louis chapel, Basilica, by Monseigneur Cazeau, P. Arthur Shee, C.M., M.D., Inverness, Megantic, to Marion, only daughter of the late James Lynch, lumber merchant.

BIRTHS.

In Montreal, on the 8th December, the wife of Alexander Proudfoot, M.D., of a son.

In Lindsay, Ont., on the 27th November, the wife of Dr. Kempt, of a daughter.

DEATHS.

In Brantford, Ont., on the 2nd of November, Reginald Digby, second son of Dr. Henwood, aged 19 years.