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JULY, 1902.

Original Communications.

THE OBSTETRICAL FORCEPS.

BY A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., ENG.

Professor of Clinical Gynæcology in Bishop's University, Montreal; Professor of Surgical Diseases of Women in the University of Vermont, Burlington.

When first requested by the editor to contribute an article on the obstetrical forceps, the writer was about to reply that he was not a teacher of obstetrics and that he had only used the forceps about two hundred times, including consultation cases, and, consequently, that there were many others who were much more able to write on this subject than he; but on thinking over his own experience, especially as a gynecologist who has taken the histories of a great many women who have been injured by the forceps and who has repaired these injuries, he came to the conclusion that he might do some good by giving his experience of the abuse of the forceps as well as by expressing his views as to when and how they should be used. No attempt, therefore, will be made to write a classical or library article, and no books will be referred to or quoted; the opinions he will express are based on about twelve hundred and fifty obstetrical and seven thousand gynecological cases, which, of course, is a very small number when compared with the vast aggregate of cases which might be drawn upon for information. And yet the careful consideration of even these few cases may be of value to the younger and less experienced of our readers to whom it is especially addressed, while the older ones may take some interest in approving or condemning it in the light of their much greater knowledge of the subject.

The Use of the Forceps. If any general practitioner of mature years were asked which of the many instruments in his possession he could least afford to do without, he would, on looking around his various shelves and bags, finally rest his eyes on his long black bag and, almost affectionately reply, the forceps, as he thinks of the many lives and the amount of suffering it has enabled him to save. But it cannot be denied that the forceps is an agent which is as potent for evil as for good, according to the motives which prompt its employment and the skill with which it is employed. The forceps has saved the lives of hundreds of mothers, but it has shipwrecked the lives of thousands. And while it has saved the lives of thousands of children who would have perished from prolonged compression in a narrow pelvis, it has killed a great many who would have passed safely through if they had been allowed a little more time. The object of this paper will be to point out how the forceps may be made to accomplish the maximum of good with the minimum of harm. There are a few simple rules which the writer has laid down for his own guidance, and which he has often pointed out to his students at his gynecological clinics when examining severe lacerations of the cervix, vagina and perineum.

1. Never use the forceps until the woman has been twenty-four hours in labour if a first confinement, or twelve hours if a second or subsequent one, unless there is some urgent indication to do so.

2. Never use the forceps to save one's own time.

If these two rules were invariably followed there would be a tremendous falling off in the number of women with lacerated cervices and perineums, and consequent puerperal infections and uterine displacements. In taking the histories of nearly four thousand cases at the Montreal Dispensary I have learned that a great many women, who stated that they had never been well since their first confinement, were delivered with the forceps in from one to six hours after the first pain of their first labour. The following extreme cases appears among the histories: A woman who came with a laceration through the perineum and sphincter ani and about two inches up

the bowel, as well as having a star-shaped laceration of the cervix and bands of scar tissue running across the vagina in every direction, stated that she had the first pain of her first confinement at eleven p.m., while spending the evening at her father's house, which necessitated her going home. She walked thither a distance of half a mile and as she and her husband had to pass the door of the physician who was to attend her, the unlucky idea occurred to them to stop at the doctor's and let him know that labour had begun. Instead of telling them to go home and go to bed, and that he would call around in the morning, he unfortunately got up and dressed and arrived at her house before twelve. By midnight he had put her to bed, examined her and decided to apply the forceps forthwith. During the next four hours, she said, he applied the forceps thirty times, although, as he did not use any anesthetics, she was unconscious most of the time from fainting, but her husband told her that several times the doctor fell on his back on the floor owing to the instrument slipping off the child's head. At last at four o'clock in the morning he told the husband that he could do no more as he was exhausted, and that he had better get another doctor. Dr. Gaherty, who sent the patient to me afterwards, then took charge of the case and found her in a very dangerous condition. By eight o'clock he had revived her enough to give her an anesthetic and terminate the delivery with instruments. This, of course, was an extreme case, but there were many other women who stated that the instrument was applied in two or three hours after the first pain. The majority had been attended by a physician whose fee was cut down so low that it was impossible for him to devote the necessary time to the case and yet make an honourable living.

I am almost ashamed to mention such a thing in a paper on the abuse of the forceps, but it must be truthful in order to be of any use, and so I must say that there are many women and still more children lying dead and buried to-day who would have been alive and well if the physician had demanded and been paid a sufficient sum to remunerate him for the time which should have been spent in

order to do good work. Rather than reduce our service to the level of an absurdly small fee, would it not be better to educate our patients up to the level of paying a reasonable fee, if they can afford it, or attend them for nothing at a maternity hospital, if they are poor? The forceps, of course, will not be employed too soon in such a place, either to save the medical director's time or to give practice to the medical student. I have made it a rule not to attend a woman in her confinement unless she has engaged me several months beforehand, among the many reasons for this being the importance of seeing her a few times in order to instruct her on the time required for a safe delivery. The writer has saved himself much annoyance and his patients much danger by the following method of *avoiding the use of the forceps too soon.* Each primipara is given three one-grain opium powders, one to be taken every hour as soon as the pains begin, and if the pains begin in the night she is told not to awake her husband until the usual hour in the morning, nor let the doctor know until 9 a.m., as it is most important that her first confinement should take at least twenty-four hours if possible. Then she is told the reason why; that if she has a natural confinement she will have better health than ever, while if it is hurried artificially she may become a chronic invalid for life. The result is that, supposing she is taken with her first pain at 11 p.m., she takes her powder and perhaps goes off to sleep only waking for a minute at long intervals; she may not even have to take the three powders. In the morning she takes an enema and a bath, puts on clean clothes, has her breakfast and then sends me word. I make my first visit about 10 a.m. and after sterilizing my hands I make the first examination and find perhaps that the os is opened to the size of a quarter-dollar. I tell her that everything is going on well and that the baby will probably be born before midnight. She is told to busy herself with her household duties between her pains, and that I will return again in the afternoon. On no account should the doctor remain in the house all day, for if he does he will almost surely be urged to do something which his judgment tells him would be detri-

mental to the patient's welfare. At the afternoon examination the os will perhaps be dilated as large as the palm, and at the evening visit the head will probably be entering the pelvis and I then remain if I have no other visits to make. But even then I do not remain all the time in the sick room, nor do I make any more examinations, but I order the nurse to call me only when she sees the head showing a little at the vulva. A little bottle with a sprinkler on it, filled with a. c. e. mixture (alcohol one, chloroform two, and ether three parts) may safely be handed to the patient, with a cone made with brown paper and a towel, and she may take a whiff of this whenever a pain comes on if it is strong; just before the head comes through the vulva I take the cone and bottle from her and put her quite asleep for a few minutes. When the confinement is managed in this way the forceps will be used very rarely. It has been mentioned above that three examinations should be made; but if the physician sees any way in which one or two of them can be avoided, let him do so, *for the woman's safety increases with the fewness of the digital examinations.* If none at all were made, puerperal sepsis would be almost unknown. So much importance should be attached to this that the writer tells the woman when she engages him not to allow any one but him to examine her, and not even him more than two or three times.

It is well also to warn the patient that we are going to make as few examinations as possible *for her sake,* in order to circumvent the machinations of the old women who call us in to make an examination every time the patient has a pain. After the lapse of so many years it is amusing to look back upon the scenes of one's early confinements, although at the time they were tragic enough; as one entered the darkened and ill-smelling rooms one felt like an innocent man on trial for his life by a jury which has already made up its mind to convict him, when through the gloom we saw the pessimistic faces of the six old women with tea-tanned faces who were there for no other purpose than to sit in judgment on the young doctor. What a howl of condemnation they set up when after

an examination he announces that he is going home, as the labour has just begun. More than once the writer has weakly stayed only to be harassed and tormented for twelve weary hours by the disparaging remarks of the jury, such as, "Can you do nothing for her?" or, "Hadn't you better call a more experienced doctor ?" until weary and goaded to desperation he has committed the almost unpardonable crime of applying the forceps in the very middle of a normal labour. Many a time the blame for using the forceps too early and thereby wrecking the woman's life should be laid at the door of these old women, rather than at that of the young physician.

Are the injuries to the mother due to the use of the forceps, or to the abuse of it? The fact that, in my own experience at least, I caused more damage with the forceps in my earlier years than I do now, would make me believe that much of the terrible injury which the forceps inflicts is due to the too early and too violent use of it. I once saw a practitioner apply the forceps early in labour, and, bracing his two feet against the woman's buttocks, he extracted the child by sheer force. During the last ten years I have caused very little damage with the forceps. In fact, when properly used, the forceps not only does not cause lacerations of the perineum, but actually saves the perineum by taking the weight of the head off it as the handles are raised, and guiding the head forwards and upwards instead of leaving it to obey the forces which are driving it down upon the perineum.

When to remove the forceps? As the forceps, no matter how delicate in structure it may be, must take up some room, I think it is best to remove it before the longest diameter of the head comes through the vulva. As soon, therefore, as I am sure that the upper jaw of the child can be reached by the right finger in the rectum, the screw holding the blades together is unloosened with the left hand, and first the female and then the male blade is removed, the right finger in the rectum all the time keeping the head down on the perineum. When the next pain comes, the head is pushed forward under the arch of the pubis and it is thus born without the perineum

being torn. When the rectum has been washed out by a soap and water enema there is nothing unpleasant about putting the fingers in it; but the enema is of advantage for another reason, namely, the saving both patient and attendant the mortification of having the bowels moved in the bed as the head comes down.

No force should be employed in applying the forceps. While studying in London twenty-five years ago, the writer received a lasting impression by reading the report of the trial of a doctor for malpractice, who, while partially intoxicated, forced a blade of the instrument through the vagina into the peritoneal cavity, and then, when several feet of small intestine prolapsed, he cut the latter off thinking that it was the cord. Whenever I am introducing the forceps this case comes to my mind and I am extremely careful not to use any force; if I cannot get it on without force I will not use the instrument at all. In fact, in most of the cases the blades drop in by their own weight.

How to apply the forceps. Although I have often seen them applied, while I was in England, while the patient was in the left lateral position, I think there is no comparison between that and the dorsal or lithotomy position, with the hips well over the edge of the bed and the feet on two chairs, or, better still, held by a leg holder, or failing that, by two women. I never attempt to apply the forceps while the woman is in the bed and lying on her back. The male blade is taken between the thumb and finger of the left hand and allowed to hang vertical, while two fingers of the right hand guide it between the head and cervix, when the handle is allowed to fall a half a circle, and the blade will be above the brain. The hands are again quickly washed and the same thing done with the female blade, only in different hands. When the two handles have fallen or are depressed a good half circle the locks will come together and the screw is tightened. The blades are then applied transversely to the mother's pelvis where there is most room, but as the child's head has to rotate forwards in the pelvis I sometimes take the forceps off when I get the head in the pelvis and re-apply them to the sides of the child's head before beginning to raise the handles.

Choice of instruments. Having in my earlier years of practice called several senior practitioners to my assistance in difficult cases, and having in turn been called by a great many younger men since, I have had opportunities of comparing the various makes of forceps, and so far as I am personally concerned, if I had to buy a new pair now I would choose the same pattern as those I bought a quarter of a century ago and have used constantly ever since, namely the Baudeloque. (I have several other kinds, but keep them merely as curiosities.) This instrument is a foot and a half long and a pound and a half in weight. The handles are roughened and each has a hook on it, which, with the rough handles, is a great help when traction is required, although I seldom use the forceps in this way, preferring as much as possible to employ it as a lever, with the arch of the pubis as the fulcrum; the long handles enabling one to exert sufficient force in this way with only one or two fingers of one hand on the instrument. One might fear that this would injure the soft parts covering the pubic bones, but such has never happened in my hands. In many cases, when the head was arrested in the pelvis, I have been able to deliver without applying a single ounce of traction. Laying the handles on the open palm of my hand, I have raised them until they touched the woman's abdomen, describing exactly half a circle, by which time the head had passed the vulva. But it is in cases where there is a narrow pelvis, with the head arrested at the brim, and the uterus is lashed into an ineffectual fury by the pains, threatening every moment to rupture itself, that I have found these forceps so useful. When they are applied in these cases, we must pull downwards until the head enters the pelvis, and after every pull wait a moment to see in what direction the handles point before making the next pull, when they will be found each time to point a few degrees of a circle higher up. These forceps have this great advantage, that they will do equally well in the most difficult and in the easiest cases. One woman I remember, who had had two confinements, each time requiring the assistance of three doctors and the child having to be killed both times. She came to me

for her third delivery, and as she was anxious to have a living child, I advised symphysiotomy, to which she consented. As soon as labour set in she entered my private hospital and all preparations were made to operate, but before cutting the pubic arch I made one attempt to deliver by applying the forceps high up. This was easily done, the male blade catching the child's forehead and the other the occiput. It was the projecting promontory of the sacrum which held the head back, but on applying some considerable traction downwards I felt a clicking sound as though the right parietal bone had bent or cracked, and the head came down. On raising the handles delivery was easily effected without any injury to the mother and with a living child which the parents so much desired. I looked for a fracture of the parietal bone, but there was no sign of it; it may have been elastic enough to bend without breaking. I attribute my success in this case entirely to the long forceps.

Care of the forceps. This same pair of forceps has been in use for nearly a quarter of a century, but it has been well taken care of. I have never once entrusted it to any one else to clean for me, but immediately the child has been born I have returned it to the jug of hot water from which I had taken it, and as soon as the mother and child had been cared for I have washed and dried the forceps myself, finishing the drying by sterilizing it on the hot stove. Every few years they are re-silver-plated, and now they are as good as the day they were bought.

Danger of using the forceps when there are no uterine contractions. I have already mentioned the danger of using the forceps to terminate labour when labour has either not begun or is only half over, from the point of view of lacerations of the cervix, vagina and perineum, but I wish to say a few words about inversion of the uterus from this cause. I have noticed that this terrible accident is more common in the practice of those energetic but misguided gentlemen who convert their normal labours into *accouchements forces* in most of the cases in which the child is not borne before they reach the house. Either there is uterine inertia, and they have to apply the forceps for

this reason, or else there is retained placenta, and they have to introduce their hand and arm as far as the elbow to remove it. Now it is absolutely and mechanically impossible for the uterus to contract itself inside out. If it is inverted, it is because it has been pulled inside out by some one; and the only two people who can do that are the baby and the accoucheur; neither of them can do it except in one way, and that is through the cord. And not even then, unless while the uterus is relaxed between the pains. Sometimes it is unavoidable because the cord is abnormally short, or it is twisted around the child's neck several times so that it becomes abnormally short, and as the child drops out of the vulva the fundus is pulled down with the placenta as soon as the uterus relaxes. Or the fundus is pulled down during an interval between pains by tractions on the cord while delivering the placenta. But when the forceps is used in the total absence of contractions there is absolutely no reason why the uterus should not invert every time. I was telegraphed for to come to the country to help a medical friend, where, the forceps having been applied in the absence of pains, the child was immediately followed by the placenta still attached to the fundus. Before I could get there the woman was dead from hemorrhage and shock. In this case the cord was wound three times around the child's neck, and before it could be undone the uterus was inverted.

Injury to the child's head. There is no doubt that many children have been killed and many others maimed for life from injuries to the head caused by using undue force with the forceps. But all these deaths must not be charged to the forceps alone; many of these children would have perished as well as their mothers had delivery not been terminated by their aid. In the writer's own hands, out of over twelve hundred deliveries, about twelve children, or one per cent., have died from instrumental deliveries, but he has only seen one case of severe injury to the brain among those who survived. This was a large boy, whose mother had a generally small pelvis, and after waiting twenty-four hours the forceps was applied at the

superior strait and the child delivered with great difficulty. Just over the right parietal bone a hole was found through which about a teaspoonful of brain substance exuded. The wound was carefully treated and, instead of the child dying as was expected, it made a good recovery. This case was followed up with interest until the child was five years old, when he disappeared from view, but when last seen he had a small pulsating tumour at the spot referred to as large as a quarter of a dollar, but he was not paralyzed in any way. I have heard of several cases in Montreal where idiocy, imbecility, paralysis and convulsions have resulted from forceps injuries to the brain.

There are many other things about this instrument which I would like to say, but the space at my disposal is limited and I must bring my paper to a close, with the hope that what I have said may induce many young practitioners to give nature a fair chance before resorting to the forceps.—*Philadelphia Medical Journal.*

ÆGOAPIOL (SMITH), IN DISEASES OF THE FEMALE.

BY CHARLES H. SHEPARD, M.D.,

Physician to Lincoln Hospital, Durham, N.C.

A deep and general interest is attached to all knowledge pertaining to the treatment of common diseases of the uterus, to which women are subject, and a vast literature is the outcome of this profound and focussed interest. We live to-day in an age of transition—a period of change. A great many of the former theories in medicine are fast passing away. New medicines are made, achieve a short-lived success, and then pass on to obscurity. This is true most especially in medicines for gynæcological diseases. Of the newer remedies it is hard indeed to get one that may be depended upon for long. They soon lose their reputation and potency and are relegated to the past.

We know that all diseases of the womb have not the same etiology nor the same pathology, therefore they should not all have the same treatment. Far too often the general

practitioner groups all these diseases together as one and gives the routine treatment. It is not enough to give anodyne medicines for dysmenorrhea no more than it is sufficient to treat alike all forms of dysmenorrhea.

The operation of curettement has a most important place in these conditions, but like other remedial agencies it has its limitation. When we curette the uterus we rid it of a pathologically obnoxious lining membrane, and afford a normal membrane the opportunity to be formed.

The healthy woman with normal genitalia menstruates regularly and painlessly once a month from puberty to the "turn" of life, except that this regularity is interrupted by pregnancy and afterwards by lactation. Any departure from this rule constitutes an abnormality. Amenorrhea is less frequently met with than dysmenorrhea and irregular menstruation. The present age of transition has brought forth what is popularly known as the "new woman," and she has brought with her new ideas and practices which in very many cases retard growth and the natural process necessary for perfect health. For leaving the old landmarks, she has to suffer.

The most generally useful medicine in the conditions of amenorrhea, dysmenorrhea, irregular, scanty and fetid menstruation in my judgment, is a preparation of the Martin H. Smith Company, of New York, known as Ergoapiol (Smith). In the female ward of the Lincoln Hospital, Durham, N.C., I have used this medicine very extensively, and it has not only never failed to benefit and cure, but I know no remedy with which I could replace it were I deprived of it. Its efficacy may be tested by any physician who properly tries it. I mention a few cases with short description of each, in which it has given the most signal benefit in my hands.

Ergoapiol (Smith) is put up as a small capsule, and is made up of a special form of apiol, which is of the the very highest quality. Combined with this are some other most valuable hemagogues, and they all go to make a fine preparation. It seems to be a scientific pharmaceutical preparation, non-

toxic, tonic, as well as emmenagogue. What I have to say of this preparation is based entirely on clinical experience, and I feel safe in saying that it will bear a clinical test whenever properly administered.

REPORT OF CASES.

No. 1. Mrs. F. was admitted to hospital September 15, 1901; married; no children, though she had been married four years. Had not menstruated for seven years. Womb had been curretted several times; suffered from leucorrhea; pains in right and left iliac regions continuous. Examination showed a very small os, but generative organs were otherwise found to be normal. Another curettement failed to bring on the menses. I then prescribed Ergoapiol (Smith), to be taken one capsule three times a day, and afterwards increased to one capsule four times a day. After seven days of this treatment she complained of a general feeling of stiffness in her limbs, gaping and a feeling of malaise. The following morning she found, to her delightful surprise, that she was menstruating for the first time in seven years. At that time the flow was somewhat scanty, but the treatment was continued through three periods. Each succeeding period was more nearly normal than the one that preceeded it. Now her functions are regular, and I know no reason why she may not become pregnant.

Case No. 2. Mrs. S. complained of a continuous, dull, dragging pain, situated in the region of the iliac fossa of the right side. Menstruation irregular, scanty, fetid. Married six years; had never been pregnant. Excessive leucorrhea, though otherwise she was perfectly normal. Her weight was 140 pounds. Her condition and the suffering, both physical and mental, which it occasioned her, was rapidly undermining her health. She was becoming emaciated, appetite of no consequence, general weakness. She considered her condition "hopeless." Cardiac weakness, of which she was a victim, contra-indicated curettement—which usually cures "whites," and allows the formation of a healthy lining membrane. Ergoapiol (Smith) was prescribed for her, one

capsule three times a day. In conjunction with this I gave tonic medicines. After six weeks' use of this remedy the woman said she was "feeling so good" that she did not need any further treatment. She had increased in weight, and her appetite had become all she could wish. The menstrual flow was increased, and now, five periods having elapsed from the time treatment was instituted, her monthly flow has failed to appear. She does not expect its return for some time—supposing herself pregnant.

No. 3. Miss S. suffered severe pain each month, beginning a day before the flow came on. The flow was a thick, clotted mass, consisting of membrane and the menstrual blood matted together. She had suffered from puberty, and the suffering became more intense as the years passed on. She was 19 years of age, stout, of healthy parentage. Admitted to Lincoln Hospital, January 15, 1902. She declined an operation. I afterwards prescribed Ergoapiol (Smith), and have continued it for one month. Her next menstruation was free and easy; painless and regular. I doubt not that keeping up this treatment to another period she will be entirely rid of the hitherto troublesome condition.

No. 4. Miss W., tubercular history. Menstruation very irregular, sometimes three, sometimes five weeks between periods; very painful; scanty. I prescribed Ergoapiol (Smith), one capsule four times a day beginning one week before the menstrual period and continued a week after the period. As a result of this treatment the patient feels a great deal better in her general health; her monthly flow has been rendered painless and increased in quantity. Ergoapiol has a tonic action upon the muscular fibres of the womb. Its effect is not transitory but lasting. This superior preparation is decidedly tonic.

No. 5. Mrs. D., a victim of endometritis. Pain continues between periods and is aggravated at periods. Leuchorrea was very pronounced; pains in the back; "hot flushes"; vertigo, headache. Patient would not allow an

operation; highly sensitive. Several preparations were tried, but none gave relief until Ergoapiol (Smith) was used. It has entirely relieved the patient, and she is now loudly singing its praises. In this case treatment was kept up for ten weeks.

Case No. 6. Mrs. D., widow, aged 33, had three children; youngest 10 years of age. She had suffered all her menstrual life severe pains in the pelvis at each period; had to keep in bed a week or more each mouth; paroxysms of pain were followed by a flow of the "whites"; no anæmia; womb found to be flabby and relaxed; pains extended down thighs posteriorly. Had been treated for many years by various physicians of note, but had received only temporary benefit.

Ergoapiol (Smith) was given her, one capsule three times day, and increased at the time of the flow to four a day. After three months of this treatment her menstrual function became regular, and, being entirely well now, she feels that life, after all, is worth living.

Ergoapiol has never failed in my hands. It is not possible that it can cure obstructive dysmenorrhea, but with that exception it is indicated in all the other diseases of the womb where a tonic and seditive action is the requirement.

I could prolong this list indefinitely with records of cases that have been entirely relieved of these conditions, and I shall be pleased to furnish any information desired as to Ergoapiol (Smith) and its use.

Durham, N.C.

Selected Articles.

RECURRENT MALIGNANT DISEASE OF TESTICLE.

BY A. CARTER WEBBER, M.D., CAMBRIDGE, MASS.

Mr. D., an active, energetic business man, married, robust and florid, had been in good health, except for an eczema on the hands and legs, previous to the summer of 1894. At that time he noticed an enlargement of the left

testicle which steadily increased, without pain or tenderness. When he came under my observation, October 3, 1894, the enlargement of the organ was about the size of a large goose egg. It was hard, firm, smooth, non-elastic, free from adhesions to the scrotal tissues, having none of the feel of the testicle on the right side. There were no indications of inflammation, such as pain, tenderness or heat. The cord was somewhat thickened, but otherwise normal. The epididymis seemed fused to the testis; the inguinal glands were not enlarged.

In spite of active treatment the testicle continued to increase in size and was removed November 7, 1894. A section of the organ displayed the usual macroscopic appearance of malignant disease—cutting crisply, slightly concave surfaces, pearly white, no defined edge, yielding a creamy fluid on pressure. One or two small cysts containing serum were found. No microscopic examination was made. Under antiseptic treatment the wound healed without difficulty, and the patient soon returned to his business and continued in good condition until the autumn of 1900, when he had a recurrence of his old trouble on the right side, the other testicle becoming affected.

In November, 1900, he came under my care and treatment. At that time the testis was three times as large as normal, but was free from pain or tenderness. It was solid, smooth, inelastic, and gave him no inconvenience except from its size and a dragging down sensation. He reported that the functions of the organ were somewhat impaired. He was then 50 years old. No improvement resulting from my treatment, the cord being somewhat thickened and the inguinal glands considerably enlarged, I began to resort to the use of the Alexander fluid, 5 minims every second day, injected directly into the external surface of the testicle which was not adherent to the tissues of the scrotum. This was continued for six weeks, when a very decided improvement in the size and feel of the testicle and cord was apparent. The hypodermic injections were then made every four or five days until April 13, when the organ was reduced to the usual size, and felt like a normal testicle. The thickening of the cord and the enlargement of the inguinal glands had disappeared.

As a precaution he receives treatment once in three or four weeks, but says he feels like himself again.—*International Journal of Surgery.*

A NEW AND EFFICIENT REMEDY FOR MALIGNANT GROWTHS.

BY J. G. JUSTIN, M.D., PH.D.

Fellow of the Monroe Co. Medical Society, New York.

The recent report of Professor Gaylord to the State authorities at Albany, N. Y., embodying the results of his researches into the cause of malignant tumours, has aroused widespread interest and started a train of investigation which is certain to add greatly to our knowledge of the disease.

Leaving the distinguished professor to prove his discovery and trace out the life history of the interesting parasite, if parasite it be, that from time immemorial has played such havoc with human anatomy, permit me to call the attention of the profession to what I conceive to be a far more important discovery than the cause of malignant tumours, namely, an efficient remedy for their relief, a remedy capable of lessening the mortality from this dreadful malady, and as potent in cancerous affections as the anti-toxin serum is in diphtheria.

Although the attention of the profession was called to the new agent over a year ago by its discoverer, Dr. A. C. Alexander, who submitted ample evidence of its value, it has failed to attract the notice it deserves, and so far as I can determine I am the only practitioner in Central New York who has made anything like a systematic trial of its virtues.

My own experience with the "Alexander remedy" for malignant growths extends over a period of nine months; and the results have been so remarkable as, in my judgment, to justify the claims made for it by its discoverer and to remove any lingering doubt, in my own mind, that it possesses a marked curative value in cancer.

As a preliminary to a test of the new remedy I made a visit to the Alexander Sanitarium, where I became conversant with Dr. Alexander's methods and witnessed the daily treatment of a variety of malignant tumours.

On my return to Rochester one of the first cancer patients to come under my care was a man with a recurrent epithelioma of the nose and face far advanced.

The history of this case is as follows: Two years ago the disease began as a small ulceration on the mucous membrane of the right cheek, opposite the second molar tooth, and gradually extended until it involved the gums and alveolar process of the lower jaw. At this stage his physician advised an operation, which was performed at the

Homœopathic Hospital, the whole of the alveolar process, together with the diseased tissue on the right side, being removed. He made a good recovery and for a time believed himself cured. Some months later, however, the disease appeared in the nose and extended rapidly to the adjacent tissues.

He was now prevailed upon to try a celebrated cancer doctor in Rochester, who claimed to have a wonderful paste that would only attack cancerous tissue. Two applications destroyed about one-third of his nose, resulting in such disfigurement that he declined further treatment.

When he presented himself to me he was a most discouraging-looking subject. The right ala of the nose was entirely gone, and a portion of the upper lip, on the right side, had sloughed away; the septum was destroyed, and the whole interior of the nose, back to and including the turbinated bones, was an ulcerated, sloughing mass, foul and offensive. His face, nose and upper lip were the colour of raw beef, and his general condition was so bad that he had given up his occupation.

I was unable to give him much encouragement, but advised the trial of the Alexander remedy for a couple of weeks and to be guided by the result. I began his treatment by the hypodermic injection of ten minims of the fluid into the cellular tissue of the abdomen for its systemic effect, four minims into the diseased area of each cheek, and four injections of two minims each around the border of the triangular opening into the side of the nose. The dosage in the abdomen was increased five minims each day until the maximum dose of thirty minims was reached, after which the latter dose was administered every other day. The diseased tissues of the nose, lip and cheeks were injected every fourth day, using from two to four minims according to situation, and giving not more than four injections at each sitting. The ethyl chloride spray was used to prevent pain from the introduction of the needle, and no constitutional or local disturbance of any moment resulted, the fluid being readily and quickly absorbed. The interior of the nose, after being cleansed of the secretions, was washed with hydrogen dioxide and sprayed with the Alexander fluid.

The result of this treatment persisted in for twelve weeks has been the apparent arrest of the disease. The patient has gained thirteen pounds in weight, has a good appetite, is strong and has resumed work. There is now

comparatively little discharge from the nose, and it is no longer offensive. The skin covering the face, nose and upper lip has lost its red infiltrated appearance, and where there was a loss of substance there is now a distinct restitution of tissue.

When this patient came to me he was past surgical aid, the caustic treatment had failed to ameliorate his condition, and we must, therefore, conclude that his improvement is due to the Alexander remedy.

Mr. S., aged fifty-five years; mother died of cancer of the liver, and father of cancer of the throat. This patient was referred to me for treatment by Dr. F. O. Webber, of Boston, who diagnosed his disease primary epithelioma of the tongue. Examination showed a papillary growth about the size of a silver three-cent piece, with a hardened base, situated on the anterior third of the tongue to the left of the raphé On either side of the growth and slightly in advance of the same were two small indurated patches of a lighter colour than the surrounding tissue.

The treatment of this case was as follows: Four minims of the Alexander fluid was injected into the tongue, just outside the growth, the needle being inserted at an angle of forty-five degrees and directed toward the centre of its base and penetrating well below the tumour. Ten minims were injected into the cellular tissue of the abdomen for its systemic effect. The injections into the tongue were made every fourth day, as described, until the cancer was encircled by ten injections. The fluid was administered in the abdomen ever other day. Following the tenth injection into the tongue, the tumour sloughed out entire, leaving a healthy looking wound, which in ten days had healed perfectly, leaving no trace of the site of the growth. The case is still under observation, but, as yet, there is no indication of further trouble.

Other cases of cancer under my care are progressing favourably, but are not far enough advanced in treatment to enable me to report them.

The remedy is said by its discoverer to be a solution of a new organic compound formed by a union of hydrocarbons and a dimethyl ketone, to which are added essential oils, forming a solution represented by the formula $C_{27}H_{17}O_2$.

It is a clear, almost colourless fluid, with a strong aromatic odour.

But be the formula what it may, the agent has a marked specific action on cancerous disease, both local and constitutional. No deleterious effects result from its introduction into the cellular tissue, the only care required being to avoid puncturing of important nerves and blood-vessels.

Used hypodermically, in an area infiltrated with cancer cells, the fluid works a prompt transformation, the part becomes paler and less vascular and if broken down is followed by reparative action.

Cancerous tumors, as a rule, are distinguished by great vascularity and a rapid growth. They are composed, generally speaking, of a stroma enclosing the tissue elements of an embryonic type which possess feeble vitality, being prone to undergo retrograde changes leading to ulceration and gangrene.

What is the explanation of the curative action of the Alexander remedy? In what way does it arrest the growth of malignant tumours?

It has seemed to me that it does this in the first instance by lessening their vascular supply, and in the second by a vitalizing influence on the cells themselves, or, possibly, by destroying some parasitic form of life that is responsible for the morbid phenomena. At any rate, the use of the remedy in cases where the system retains sufficient vitality to respond to the treatment is attended by a marked improvement in the condition of the patient, both local and general.

Whereas, a few months ago, I dreaded to encounter the sufferers from this disease, knowing that the resources of the healing art were powerless to afford relief, I now undertake their treatment confident of ameliorating their condition, and in cases where there is not too great loss of vitality, of effecting a cure.

In closing this report of my experience with the Alexander remedy, I am aware that my series of cases is too small to base deductions upon, but the results obtained have not been duplicated by any other known method of treatment, and they supplement a large number of cases reported by Dr. F. O. Webber, of Boston.

In view of the above I cannot too strongly commend this remedy to the attention of brother practitioners.—New York *Medical Times*, Sept., 1901.

Progress of Medical Science.

MEDICINE AND NEUROLOGY

IN CHARGE OF

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CAMPHOR DRESSING FOR VARICOSE ULCERS.

Camphor is a drug which for many years was held in great esteem, especially in extra-professional circles; indeed, the late M. Raspail founded a school of therapeutics which still rejoices in great popularity in France, based on the use of camphor internally and externally as a curative agent. Its anti-spasmodic properties, though well authenticated, have of late fallen into disrepute, or at any rate into disuse, and externally it is only employed in this country in the form of a liniment of which it is but a subsidiary constituent. Two German physicians have recently called attention to the value of camphor dressings in promoting the cicatrization of varicose ulcers of the legs which are notoriously refractory to treatment. They make use of an ointment containing 2 per cent. of camphor, with from fifteen to twenty parts of oxide of zinc, or, if this be found too irritating, they prescribe a mixture of two parts of camphor with forty parts of zinc oxide, and fifty parts of olive oil. An alternative application is a solution of the drug in spirit, but this must only be applied after the ulcerated surface has been thoroughly cleaned of scabs and crusts by poultices. It is asserted that under this treatment the most obstinate ulcer will cicatrize within three weeks, which is more than is claimed for the much lauded oxygen treatment, over which, moreover, it has the advantage of being more generally applicable at a vastly smaller cost.—*The Medical Press.*

HOME-TREATMENT OF PULMONARY TUBERCULOSIS.

Dr. Robert H. Babcock, in discussing this subject, believes that the real reason for the hopelessness on the part of the practitioner in obtaining satisfactory results in the home-treatment of tuberculosis lies in the fact that he depended too much on medicinal therapy. The most success-

ful treatment lies, not in the use of medicinal agencies, but in the hygiene of the patient's life. Although these requirements can be best secured in a sanatorium, they can be obtained at the patient's home regardless of the climatic conditions that prevail there. Food should be taken at short intervals; it should be easily digested and assimilated, and should be of the most nutritious character in the smallest bulk. Good results are obtained from the use of milk and raw eggs. The patient is ordered to drink a glass of heated but not boiled milk the first thing after waking in the morning, and thereafter every two hours during the day, regardless of his meals. Raw eggs are taken, beginning with one after each meal, and increasing by one daily until as many as possible are consumed. Exercise is to be permitted only when the patient is free from fever and a febrile reaction does not follow exercise. The patient should spend the entire day out of doors, without regard to the condition of the weather, proper precautions being taken to prevent the patient from taking cold. Hydrotherapy is highly important. The one essential condition is that all measures should be followed by a good reaction.—*Medical News.*

REMOVAL OF EAR-WAX.

Baerens (Regular Medical Visitor) says that in the removal of impacted cerumen as little instrumentation as possible should be indulged in. Much harm often follows the use of probes, forceps and hooks in untrained hands. Hardened wax may be softened by the instillation of a solution of sodium bicarbonate and glycerine and water, three times a day. In syringing the stream should be directed along the upper wall of the canal, the object being to force the water behind the plug, and not against it. If much force is used vertigo often results.

TONSILLITIS.

Dr. J. T. Crowley, of San Francisco, Cal., writes to the *Medical World* that the following combination seems to be well-nigh a specific, a rheumatic tendency being present in most cases:—

℞ Sodii salicylatis..... 1½ drachms.
Ferrous sulphate..... ½ drachm.
Liq. ammon. acet..... 1½ ounces.
Syr. Tolu.....q. s. ad 3 ounces.

M. Sig: Teaspoonful three times a day in water or milk.

A REMEDY FOR NOSE-BLEED.

Children are occasionally troubled with bleeding at the nose, and in some instances this becomes quite alarming, especially when all known remedies fail, and the weakening flow still continues; and in this instance, as in many others, the best remedy is one of the simplest that could be tried. A celebrated physician has claimed in one of his lectures that this "best remedy" is a vigourous motion of the jaws, as in the act of chewing. In the case of a child, he recommends giving a wad of paper to chew, as the rapid working of the jaws stops the flow of blood; but why not try chewing gum instead of paper?—*Western Medical Review.*

VERATRUM VIRIDE IN MANIA.

Any physician who has not employed veratrum viride in acute mania has missed the best agency which is available for the cure of these distressing cases. It is one of the greatest advantages a physician can have to see the feverish sufferer, under the application of this remedy, pass from absolute sleeplessness into a state of quiet rest. That many cases which would otherwise go on to death are saved by the use of this remedy is a fact beyond question. The fear which many practitioners have of using veratrum viride, on account of the varying strength of its various preparations, must, of course, be met, when the drug is employed, by the use of Norwood's tincture.—*American Medical Journal.*

BLOOD FOR BABIES.

In the course of the second year there comes a time when the milk diet begins to be insufficient for the growing child, and Natures calls for a change, while yet the system is in many cases unprepared for solid food. This kind of deadlock results in diarrhoea or constipation, anaemia, restlessness, fretfulness, etc. In such cases the fit and radical remedy will be found in the administration of say ten drops of bovinine in a little milk, at intervals of three hours.

Little Robert Valverdie, a patient who came under my care in the condition of malnutrition above described (after trying all the usual medical helps with no benefit), was immediately restored by the direct blood treatment. On the second day of taking bovinine, the constipation and other trouble began to be relieved, and on the third day all signs

of ill-health had disappeared as if by magic. This simple treatment was continued for three weeks, the child thriving beautifully.—Case reported by DR. T. J. BIGGS.

HYSTERECTOMY FOR CANCER OF UTERUS.

Mrs. T., age 47, American. Diagnosis, carcinoma of uterus. Entered hospital Oct. 10, 1901, in a greatly run down condition. She was put on an absolute bovinine diet, until Oct. 14, when at one o'clock she was given a high rectal injection of bovinine and salt solution, three oz. of each, and at two o'clock, under ether anesthesia, I performed an abdominal hysterectomy. Just before the uterus was detached from the vaginal wall, the patient showed considerable shock, and consequently the nurse was ordered to give her another high rectal injection of bovinine and salt solution, two oz. each. She responded to this beautifully. The operation was completed by the closure of the abdominal wound, the pelvis being drained through the vagina. Patient was put to bed with the pulse weak and 112. She was given another high rectal injection of bovinine and salt solution, three oz. of each. In twenty-five minutes she was conscious, pulse greatly improved, being 100, and full in character. *No nausea, thirst or vomiting.* The second day the vaginal drain was removed, the wound and the vagina treated by injections of bovinine pure, employed t. i. d. Previous to every injection of bovinine into the vagina, the cavity was washed out with borax solution. These injections were continued three times a day up to Oct. 16, when twice in twenty-four hours was deemed sufficient. She was now allowed a light general diet together with bovinine. Oct 24, the stiches were removed and the abdominal wound found to be healed. From this time on her recovery was uninterrupted and she was discharged cured, Nov. 16.—By T. J. Biggs, M.D., Sound View Hospital, Stamford, Conn.

PNEUMONIA.

An editorial in the *Archives of Pediatrics* for January, 1902, states, concerning the treatment of pneumonia in children, that there is less divergence of opinion among pediatric specialists than in the treatment of most other diseases, and that the practice adopted by them differs radically from that adopted by a large number of general praticians among whom the prevailing tendency is toward complexity and the use of much medicine, while the ten-

dency of treatment among men of broadest experience is toward simplicity and the use of few drugs. In hospital practice, under physicians of extensive experience, the chest is protected by flannel or a cotton jacket loosely applied, with perhaps the occasional use of a mustard paste with the desire of embarrassing the respiration, which is always laboured in pneumonia, as little as possible. In private practice the chest is too often loaded with a heavy poultice, the weight of which must be lifted from thirty to fifty times a minute by respiratory muscles already overburdened. In the one case the fact being recognized that the disease is one marked by prostration, depression and exhaustion, the strength is conserved in every way, the child is disturbed as little as possible, nauseating medicines are avoided, and nourishment is looked upon as of vital importance. In the other case the child is not given sufficient rest, the temperature is taken too often, something is being constantly done, doses are unnecessarily multiplied, etc. The author protests against the heavy, hot and steaming poultices, soon cold and soggy, the forcing down of nauseating drugs, and the frequent disturbance of the child in overzealous efforts to cure, believing that they actually save less than the simpler methods of treatment. As fever is a necessary feature of pneumonia it need cause no alarm, unless it ranges abnormally high, and it is usually worse than futile to try to force it down by the use of coal-tar antipyretics which add to the depression natural to the disease. The author asserts that the picture is not overdrawn, as such errors are very commonly seen by consultants, and emphasizes the importance of the simpler line of treatment in this disease.—*Cleveland Medical Journal.*

Dr. I. L. Van Zandt in the *Southern Practitioner* for December, 1901, believes that in pneumonia in a large per cent. of cases creosote has a decidedly curative, in fact, almost an abortive effect. He quotes Prof. A. A. Smith as asserting that the treatment by creosotal or similar germicide is capable of causing an early lysis before the time for crises arrives; and further that a large percentage of pneumonic cases are cut short or aborted, almost all the rest are mitigated, and the remainder, a very small percentage, are not affected by the remedy. He gives to an adult seven and one-half grains or minims every three hours, and in urgent cases gives the dose more frequently. He has used carbonate of creosote without other medication, but believes that guaiacol or its carbonate cannot be used instead and has also found thiocol inefficient. Dr. W. H. Thompson in the *Medical Record* for February 1, 1902, also advocates very

strongly the use of carbonate of creosote in pneumonia, and reports eighteen cases of lobar pneumonia in patients ranging from ten to forty-five years of age, which were treated exclusively by this drug; of these but one alcoholic died; certainly a very satisfactory showing, as in three of the cases both lungs were involved, and these recovered. He gives fifteen grain doses every two hours, one hundred and eighty grains in the twenty-four hours, which is three times the amount given by Dr. Leonard Weber, who recently reported nine cases so treated with but one death. Dr. Thompson gives the drug in glycerine and peppermint water, and believes that it exerts a special effect upon the course of the disease. It also favourably influences that very undesirable complication in pneumonia—tympanites. It is in his opinion better borne than the guaiacol carbonate, and he has never noted any depressing effects nor injurious action upon the kidneys. In his cases the disease terminated by lysis in twelve and by crisis in only five days. The writer has used guaiacol carbonate in these cases with benefit, but usually gives three to five grains every few hours, and as the guaiacol is the main active constituent of creosote it probably matters but little in what form it is given.—*Cleveland Medical Journal.*

SYPHILIS.

Dr. G. Frank Lydston in the *Medical News* for January 18, 1902, emphasizes the cardinal principle in the therapy of syphilis that the physician should remember that he has to deal with three factors; first, a specific disease to be controlled by specific medication; second, a distict individual personality in each patient; third, the results of antiseptic medication. There is too great a tendency to treat syphilis and absolutely ignore the individual afflicted by it. Ptyalism and iodism may both be avoided in many cases by attention to the eliminative functions. A useful point too frequently neglected is the ingestion of large quantities of water. He has succeeded in avoiding iodism in certain cases by mixing the daily dose of the drug with from two quarts to a gallon of water, and instructing the patient to drink the entire amount, a glassful at a time, during the 24 hours. Hot baths are a very useful adjunct to the treatment, increasing tissue metamorphosis, favouring elimination, and necessarily enhancing the therapeutic action of the mercury and iodide while attention to the bowels is very important. When digestive disturbances exist and gastric symptoms are stubborn, the substitution of the hypodermic

or inunction method is imperative. When lesions of the mucous membranes are very resistant to treatment, and the patient does not tolerate mercury and iodide well, he advises the substitution of the potassium chlorate for these remedies, believing that, while in no sense a specific, it has a marked and positive action of its own in syphilitic lesions, having seen most beneficial results follow its use. He recommends the combination of the preparations of iron with the mercurials to obviate the debilitating effects of mercury, and in long-standing cases considers the syrup of the iodide of iron the most eligible preparation of the drug. In the same journal Bonveyron and Siraud are quoted as having given orthoform in total daily doses of two to three grams, divided into four or six powders, with decided success in the essential headache of syphilis. Most frequently the smaller dose of the two grams, or thirty grains, in 24 hours, is sufficient to quiet all this rebellious pain. Usually a decrease takes place during the first night and after that the pain disappears entirely. For the intermittent headaches, one-half grain is given one hour before the expected return of pain, and two similar doses through the night. For the continuous pain four such powders should be given at regular intervals, say six hours.—*Cleveland Medical Journal.*

CEREBRAL HEMORRHAGE.

In *Merck's Archives* for March, 1902, Dr. William Browning presents a series of "dont's" to be remembered in the treatment of cerebral hemorrhage. Don't give stimulants. Their use in such cases is most reprehensible. Don't resort to saline injections. During the acute stage a limitation of fluids is in order. Don't use the depressant diaphoretics such as ipecac, pilocarpin or apomorphin. They tend to nauseate, an inclination otherwise too common, and, in the degree of attempts at vomiting, most undesirable. Don't prescribe digitalis. The author has repeatedly seen it bring on another attack. It is a dangerous drug in any individual with a liability to apoplexy, and for this if for no other reason of questionable utility in nephritis. When anything of the sort must be used, strophanthus is safer. Don't resort to opiates. They are likewise contra-indicated. Don't try nitrites, as their use in any form is here out of place. Don't permit any muscular exertion on the patient's part, and moving by others should be limited as much as possible.—*The Cleveland Medical Journal.*

SURGERY.

IN CHARGE OF

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INTESTINAL OBSTRUCTION.

In very bad cases of intestinal obstruction, in which, for any reason, operation has been very long delayed, we may feel like giving the patient the benefit of the only chance that remains to him. These patients are practically unable to feel pain, and administration of a general anæsthetic to them is exceedingly dangerous. Use local anæsthesia, rapidly open the abdomen, draw out the nearest coil of distended intestine, stitch it rapidly to the external wound, and open into the gut at once. Use hot saline injections by the rectum and intravenously. If we can thus tide the patient over a couple of days we may later on deal with the obstruction itself.—*International Journal of Surgery.*

THE DISADVANTAGES OF GAUZE PACKING IN APPENDICITIS WORK.

R. T. Morris, New York, states that gauze packing sometimes causes ileus and bowel obstruction by simple and direct mechanical pressure. It more often causes an excessive exudation of reparative lymph, which may result in annoying peritoneal adhesions and life-long discomfort for the patient. Its employment usually leaves a very weak place in the patient's abdominal wall, and invites the development of post-operative ventral hernia. In the opinion of the author the worst feature of gauze packing, however, is the tendency it seems to possess to depress the patient's general resistance and to prolong, if it does not sometimes also cause, the condition of surgical shock. The great misery caused by the removal of the gauze packing, when a change of dressing is made, can be described only by the patient. Since the use of iodoform has become so widespread, the danger of iodoform poisoning has been added to that of the

formerly used plain gauze. Many of these cases have been and are still regarded as being cases of septicæmia; while the symptoms of these two states are very similar, in iodoform poisoning the wound is apt to look remarkably well, while the patient does not; whereas in septicæmia, neither the wound nor the patient looks remarkably well. In the former condition, free iodine can be found in the patient's urine, and a simple test consists in adding calomel to a specimen of the urine, and noting the reaction as iodide of mercury is formed when the mixture is stirred. The author believes that it is not safe to teach that gauze packing should be at once given up, but that one should work toward the point of giving up gauze drainage as rapidly as experience proves that it can be safely done.—*New York Medical Rec., St. Louis Medical Review.*

TREATMENT OF FOREIGN BODIES IN THE ESOPHAGUS.

N. Stone Scott (*The Cleveland Medical Journal*, March, 1902) says: Treatment of foreign bodies in the esophagus will vary materially with the kind of body and complication of the case. Thus, a hard substance should be immediately removed. Nothing is gained by delay, and if allowed to remain, infection and inflammation supervene and add to the difficulties of the case. When the patient is anesthetized the foreign body can frequently be grasped by forceps or coin-catchers, and withdrawn through the mouth. If lodged as far down as the diaphragm, it can usually be pushed on into the stomach, provided there be no pathologic thickening of the esophagus at this point. Subsequent treatment of such cases will depend upon the symptoms. The patient should be allowed to recover from the anesthetic, and if no further symptoms warranting interference supervene, nothing further should be done. The foreign body will usually pass through the pylorus and the rest of the alimentary track without difficulty. Should it become lodged lower down, operative interference may be required for its removal.

When the cause of obstruction can neither be grasped by the forceps and withdrawn, nor pushed on into the stomach, the simplest and best method of relief is by an external esophagotomy. Even should it be possible to remove the body through the mouth, this same procedure in order to provide for drainage in advisable in cases in which the foreign body has been allowed to remain until the patient has become septic. The incision is made upon the

left side at the internal border of the sternocleidomastoid, the dissection carried down to the esophagus by means of the blunt instruments rather than by cutting, the various structures being pushed to one side, the esophagus is opened with a sharp instrument by a clean cut, and the foreign body extracted with as little laceration of the tissues as possible. The incision in the esophagus should be closed with a catgut, and a strand of gauze, horsehair, or other means of drainage inserted, the external skin incision being closed throughout most of its extent. It is a technical error to entirely close the skin incision, because the structure of the esophagus renders its sterilization impossible, and infection is liable to occur from the wound in the esophagus. An esophageal fistula is apt to result from the operation, but as a rule is of slight moment and will spontaneously close in the course of a few weeks. The after-treatment of these cases is simple. Nothing should be given by mouth for a number of hours until the first efforts at repair have been accomplished, although as a rule the patient will be able to swallow with little or no difficulty.

INDICATIONS FOR OPERATION IN GASTRIC ULCER.

1. Acute hemorrhage should rarely be treated by operation. The results of interference have not been good, while the results of medical treatment have been satisfactory. When, however, a hemorrhage frequently repeats itself, even though not severe in amount, it will demand operative treatment as soon as its recurrent character is plain.

2. Small frequent hemorrhages, threatening anaemia give a clear indication for operation.

3. Perforation of the stomach, either acute with general peritonitis or chronic with surrounding adhesions and perigastritis, demands instant operation.

4. When an ulcer runs a chronic course with a strong tendency to recurrence, and gradually diminishes the patient's capacity for work and the enjoyment of life, an operation is indicated, especially when the patient is so situated as to be dependent on his daily work for support, and unable closely to regulate his diet.—A. T. CABOT, Trans. Mass. Med. Soc.

CORNS.

Perhaps the best method for securing the partial removal of corns, by the application of chemical substances, is that recommended by Unna. A ring of glycerine jelly

is painted around the circumference of the corn so as to form a raised rampart. A piece of salicylic plaster-mull is then cut to the size and shape of the central depression, and applied to the surface of the corn. This is then covered with a layer of glycerine jelly, and before it sets, a pad of cotton-wool is applied to the surface. This process is repeated as often as is necessary, until the horny layer of the corn separates and is cast off.

If the point of a sharp, thin-bladed knife be introduced at the groove which runs round the margin of the corn, and be made to penetrate toward its central axis, by the exercise of a little manual dexterity the horny part of the corn can be easily made to separate from the parts beneath. This method of removal is one which is much in favour with chiropodists.

Any method of treatment, however, to be curative, must secure the removal of the entire corn together with the underlying bursa.

Having taken every precaution to render the operation aseptic, a spot is selected for the injection of the anaesthetic solution. At this point the skin is rendered insensitive by the application of ethyl-chloride, and 5 minims—more or less—of a 4-per-cent. solution of eucaine is injected into the subcutaneous tissue beneath the corn. Having waited a few minutes, the superficial parts at the site of the incision are rendered insensitive by ethyl-chloride. Anaesthesia is now complete, the process itself being painless, and the operation may at once be commenced. Two hemi-elliptical incisions meeting at their extremities are made through the skin around the circumference of the growth, care being taken that they penetrate well into the subcutaneous tissue. Seizing the parts included in the incision with a pair of dissecting forceps, a wedge-shaped piece of tissue—including the corn, a layer of skin and subcutaneous tissue, and the bursa, if present—is dissected out. The oozing is pretty free, and it is sometimes necessary to torsion a small vessel; but the haemorrhage is never severe. The edges of the wound are brought together by one or two fine sutures; an antiseptic dressing is applied, and the wound left to heal—primary union in a few days being the rule. The net result is the production of a layer of scar-tissue at the former site of the corn. It might be thought, perhaps, that the formation of a scar on an exposed position, where it was liable to be subjected to pressure and friction, would lead to untoward results; but such in practice is not the case.

The chief advantages to be derived from the complete excision of corns are that, as a method of treatment, it is

safe, speedy and painless; while the results, as far as a cure is concerned, are permanent and effected at a minimum of time and trouble. E. H. Freeland (*Edinburgh Med. Jour., Nov., 1901*).

WOUNDS OF THE THORACIC DUCT OCCURRING IN THE NECK.

Drs. D. P. Allen and C. E. Briggs make a report of two cases, with a résumé of seventeen cases in *American Medicine*, of Sept. 21, 1901.

The writers have made a careful and interesting study of wounds of the thoracic duct, and offer some valuable suggestions as to methods of procedure in dissections of the neck, and the operative treatment advisable if the large lymphatics are wounded. In operations in this region, where there is a probability of wounding the duct, they suggest that about three hours before the operation the patient be given four to six ounces of cream. They advise this, since, in the intervals of digestion, lymph so closely resembles serum that its presence is often not recognized, and wounds of the lymphatics pass unnoticed until some days before the operation. But by giving cream a few hours before operating, the absorption of fat is induced, and chyle is so characteristic in appearance that its presence in a wound would be immediately noticed and search made for the injured lymphatic. As a result of their studies they conclude:

1. The increasing frequency of extensive dissections of the neck makes it desirable to consider means of avoiding injury to the thoracic duct.

2. It is desirable that if wounds of the thoracic ducts or its branches occur, they would be recognized at the time of the operation. If there is a probability of wounding the duct four to six ounces of cream should be given to the patient about three hours before operating. This is especially desirable in secondary operations undertaken for the purpose of locating point of injury.

3. That suture of the duct with fine silk or catgut be accomplished when possible; that all small discharging lymph radicles be ligated; that the ligating and clamping of lymphatic vessels of considerable size be avoided, unless the integrity of the thoracic duct itself has been demonstrated; that where suture of the duct or large radicles is impossible, gauze packing, firmly and accurately applied, be used; that the head and neck be kept at rest, the use of morphine to a considerable degree being recommended if necessary.

4. That until the repair of the duct is thought to be complete, nutrition should be sustained on albuminous material, with possibly a small amount of carbo-hydrates, but with an absolute exclusion of fats.—*Maryland Medical Journal.*

RESULTS OBTAINABLE IN THE TREATMENT OF DENSE, TIGHT, DEEP-LYING STRICTURES OF THE URETHRA.

L. S. Pilcher (*Annals of Surgery*). In cases of retention due to a deep stricture, prolonged efforts are not made to secure the passage of instruments. If a No. 2 or No. 3 French olive-pointed bougie does not pass readily, the bladder is aspirated and preparation made for urethrotomy, usually without a guide. A free incision is made in the perineum, and if the urethra is found to be a distorted, hardened mass of cicatrical tissue, from one-half to three-quarters of an inch may be excised and the divided ends brought together. In the majority of the cases the urethra is split along its floor and a gorget introduced into the bladder, followed by the introduction of the finger. The first joint of the index finger corresponds to about a No. 60 sound of the French scale, and dilatation short of this is not advisable. The meatus and penile urethra is cut until it admits a No. 40 sound, and a sound of that size is passed through the entire urethra into the bladder. A rubber tube of about the same size is passed through the perineal wound into the bladder and held in place by sutures passed through the sides of the wound. A packing of iodoform gauze is placed around the tube. After four days the tube is removed; sounds Nos. 36, 38, and 40 are passed in succession. The tube is not replaced, and the sounds are passed every third day for two weeks, then once a week, then at rapidly-increasing intervals—once a month, once in six months, once in twelve months. There is no theoretical reason why these old strictures should not be cured permanently, as overstretched scar tissue, as seen in ventral hernia, has no tendency to contract. Some cases which have been followed for several years show that the cure has been perfect.—*Georgia Journal of Medicine and Surgery.*

CURE OF CHRONIC BRIGHT'S DISEASE BY OPERATION.

Edebohls (*Med. Record*, December 21, 1901).—The author first operated upon chronic nephritis, November 29, 1901, and while the operation was primarily a nephropexy, done for the relief of a loose kidney with nephritis, the re-

sult was a cure of the nephritis. In all he has operated upon six cases of nephrotosis with nephritis, obtaining favourable results in four. On January 10, 1898, he undertook for the first time this operation for the purpose of curing chronic Bright's disease, doing a bilateral nephropexy, with radical cure of the Bright's disease. He reports eighteen cases operated upon for chronic Bright's disease, five of which had right chronic interstitial nephritis; four had left chronic interstitial nephritis; four had right and left chronic interstitial nephritis. two had right and left chronic parenchymatous nephritis; three had right and left chronic diffuse nephritis. In fourteen of the eighteen both kidneys were operated upon; in twelve at one sitting, and twice at two sittings. In four cases operation was performed on one kidney only, in every instance the right. Two of them recovered complete and lasting health.

Chronic Bright's disease was unilateral in nearly one-half of all the cases, which fact was somewhat of a surprise and revelation to the author. He finds no difficulty in recognizing the disease in the kidney as it lies pulled through the wound before him with the blood circulating through it. From two cases a piece of the kidney was obtained. and the diagnosis verified by the pathologist.

While extensive denudation of the kidney was a factor in all the nephropexies, in the last two cases total extirpation of the capsule was done; in one, bilateral at one sitting; in the other the patient had but one kidney. The right had been removed for a septic process some months prior.

The method of operating is in part as follows: After cutting down to the kidney, it is freed from its fatty capsule and brought out through the wound to full view. The capsule proper is incised along the entire length of the convex external border and clean around the extremity of either pole. Each half of the capsule is now dissected from the organ and cut off clean to its junction with the pelvis, and removed. The kidney is dropped back in place and the wound closed without drainage, unless there is extreme edema of the parts, when drainage is used. Ether was the anaesthetic used in all cases except one.

Of nine cases operated upon one year or longer ago, one only failed of radical cure of the Bright's disease. This one had the left kidney removed by another surgeon three years later, and the right kidney, which the author had operated upon, sustained life for five years longer, when a third surgeon did a hysterectomy, from which the

patient died. Four cases were operated upon six months ago: two are free from casts and albumen; the other two show improvement. In the two last cases operated upon, the time is too short for deductions.

The author believes, especially from the above eight cases of cure operated upon one year or longer ago, that chronic Bright's disease is curable by operation, but as the time required for improvement to begin to show itself is ten days or more, and as this improvement is gradual, the late stages of the disease may not be fitted for the procedure.

While operating on a kidney on which a nephropexy had formerly been done, he observed numerous arteries large enough to require ligation, passing between the fatty capsule and the kidney with the flow of blood *towards* the kidney. This increased blood supply, most probably, leads to gradual absorption of the adventitious tissue in the diseased kidney, giving relief to the tubules from pressure, and allowing the epithelia to regenerate. The cure is gradual, requiring from one to twelve months. It is not a relief of kidney tension from removing the capsule, but of vascularization. The capsule in chronic Bright's disease never compresses the organ, although it may be adherent, but may even sit loosely upon the kidney. The fatty capsule and the kidney are both liberally supplied with blood vessels, and the denuded kidney furnishes an extensive surface for intercommunication, while the fibrous capsule proper is an impenetrable barrier to the passage of the blood vessels.

The author operates if the expectancy of life is more than a month, if there are no incurable complications, and an anaesthetic is not contra-indicated.—*Interstat. Med. Journal.*

THE OPERATIVE TREATMENT OF TRAUMATIC INTRACRANIAL LESIONS.

C. Phelps, New York, after a brief review of the principles of treatment of cranial fracture, discusses the rules of procedure for the treatment of intracranial injuries. Successful treatment depends upon correct diagnosis, and the diagnosis in turn upon accurate knowledge of existing pathic conditions. The primary traumatic intracranial lesions are classified by the author as follows:—1. Hæmorrhages. 2. Contusions; 3. Brain lacerations. Hæmorrhages are subdivided into: (*a*) Supradural or epidural; (*b*) Pial; (*c*) Cortical. Contusions are: (*a*) Meningeal; (*b*) Cerebral.

Each of these conditions are briefly discussed, together with the treatment indicated. The justifiable use of operation in head injuries is shown to be very limited. It may be summarized as properly general in depressed cranial fractures, frequent in comparatively uncomplicated epidural hæmorrhages, and exceptional in subdural lesions, whether of the brain or of the pio-arachnoid membrane. The resort to operative measures, which is essential under favourable constitutional conditions in abscess of the brain and in intracranial gunshot wounds, is not considered in this article. If, in the general class of intracranial injuries, operation is to be but infrequently done, the question of operation will often be raised, and decision as to the course then to be pursued will entail grave responsibility, since error in judgment may deprive the patient of a chance for life, by increasing the danger of an already critical condition.—*N. Y. Medical Journal.*

Jottings.

STYES.

When repeated attacks have occurred the lid-edges should be thoroughly smeared every day for three months, with

Aristol..... 7½ grains
Vaselin.....
Lanolin.....aa 75 grains.

—*System of Practical Therapeutics*, 2nd Edition, 1901. Edited by Dr. H. A. Hare.

ACUTE RHEUMATC PHARYNGITIS.

In cases in which the pain and muscle soreness are limited to the region of the throat, three to five grain doses of Salophen every three or four hours will quickly relieve the soreness and pain.—*System of Practical Therapeutics*, 2nd Edition, 1901. Edited by Dr. H. A. Hare.

LINSEED MEAL POULTICE.

Warm a basin, pour in boiling water, sprinkle in the meal, stirring vigorously, till it becomes of the consist-

ency of thick porridge; spread on tow or old linen, turning in the edges all around; before applying put it against one's cheek to feel that it is not too hot. Retain in position with a broad flannel roller, secured with safety-pins. Renew every four hours or oftener. The poultice should not exceed half an inch in thickness. Caution is necessary in poulticing the chest of infants in order not to overload the chest and tire out the respiratory muscles. Ashby and Wright (*Pediatrics*).

FOR PUERPERAL ECLAMPSIA give green root tincture of gelsemium, hypodermically, in thirty to sixty drop doses.

A SMALL QUANTITY of acetanilid dissolved in the mouth in contact with an aching tooth will often give quick relief.

HYPODERMIC INJECTIONS of pilocarpine, fifteen or twenty minutes apart, have relieved severe cases of edema glottitis.

GUAIACOL mixed with an equal part of glycerine and applied over the seat of a neuralgic or muscular pain will often give quick relief.

A SPOON IN A GLASS filled with hot water prevents the breaking of the glass, because the metal rapidly absorbs a large part of the heat.

A SOLUTION OF five grains of tannin to an ounce of water is a very serviceable application to sore nipples. Apply night and morning.

IN SPASMODIC URETHRAL STRICTURE give cimicifuga and gelsemium in full and frequent doses. Good results may be looked for in three hours.

ALOES APPLIED TO an ulcer or denuded spot will as effectually and as promptly prove cathartic as when administered in the usual way in pill.

AN INCIPIENT COLD in the head can be checked every time if the nose is thoroughly rinsed out with a weak solution of potassium permanganate.

IT IS STATED THAT 75 grains of picric acid dissolved in two ounces of alcohol, to which a quart of water is added, makes an excellent application for burns.

FOR MOIST CONDYLOMATA appearing on the genital organs, a powder composed of equal parts of burnt alum and tannic acid is said to be an admirable remedy.

LOBELIA in small and often repeated doses, especially when used in combination with ammonium carbonate, ipecac or grindelia, is a stimulating expectorant.

TEN DROPS EACH of chloroform and tr. aconite mixed and applied locally will instantly relieve pain, especially of sciatica, and this disease when treated thus two or three times a week will soon cease to return.

DR. RUMBOLDT says that he always sprays the nasal cavity with vaseline as hot as can be borne by the patient, after any operation in the nose which causes hemorrhage. No matter what the amount of hemorrhage, Dr. Rumboldt says this will always promptly check it.

A PAROXYSM OF PERTUSSIS may be prevented or cut short by placing the forefinger on the root of the tongue and pressing gently downward and outward till the spasm of the epiglottis is overcome and the larynx opened for the admission of air. This will save many a moment of terrible agony, and many a child from death by asphyxia.

Therapeutic Notes.

ACUTE NASAL CATARRH.

℞ Carbolic acid, 8 minims.
Ichthyol, 1 drachm.
Diluted alcohol, 2½ drachms.
Aquae destillatae, ad 3 ounces.
M. Sig.: Use as a spray, by means of atomizer, two or three times a day. (*Journal of the American Medical Association.*

TO ABORT FURUNCLES.

Calcium sulphide in doses of $\frac{1}{10}$ grains will usually answer this purpose; increased to ½ grain, pus formation is inhibited with almost certainty.

THE

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Editorial.

Charges of carelessness against hospitals, accompanied by suits for damages, have fortunately been rare in Canada. They are, however, not unknown, though we think, in most cases, the suit for damage has been brought against one of the hospital's medical officers. Such a case was recently tried in Montreal, where a medical man attached to our largest hospital was charged with removing a foot without the patient's consent. The case fortunately failed, inasmuch as it was proved beyond any doubt that the action of the surgeon was in the best interest of the patient. Still, from some remarks which were made by the judge, it was clear that in the case before him, the line of demarkation was closely touched, and that it would not have taken much to turn his judgment in the opposite direction. Medical opinion as to justifiable action does not always commend itself to the legal mind. In cases which we have known, and where it seemed clear that the action of Medical Corporations was in the very best interest of the public—the Courts have decided that the action taken was not legal. It must be remembered that the mental ducation of the medical and legal profession is different. The former looks

upon himself as a proctor of the public—the latter simply as the administrator of the law. Whether that law is in the interest of the public is not taken into consideration, and though those who passed it may have so intended, its wording may fail to have it so interpreted. We find that our brethern in New York and Buffalo have had some reason of late to conclude that law is not always justice. In the Buffalo *Medical Journal* for May we find the following article, which we commend to the very careful consideration of our readers, but more especially Hospital Surgeons. It would also be well if these gentlemen brought it to the serious attention of the Lady Superintendents of Hospitals. If such actions were to be taken against our Canadian Hospitals, and the same legal decision arrived at, it would indeed be a serious matter.

"There has been decided in New York City a case which has a peculiar interest in Buffalo, inasmuch as it will affect the question of the payment of damages by two Buffalo hospitals.

"Something over two years ago Helen G. Ward was taken to St. Vincents' Hospital for operation. At the conclusion of surgical procedures she was placed in bed and a nurse in charge of the case put hot water bags about her. She suffered burns more or less severe from these hot water bags. When she left the hospital she brought suit for damages against the hospital and was by direction of the court non-suited. An appeal resulted in a new trial being ordered, in which case the jury disagreed. A third trial was secured, and the jury gave Miss Ward a verdict of $10,000. The hospital's attorneys prepared papers in appeal and carried up the case. The Appellate Division set aside the $10,000 verdict and ordered a new trial on errors. The case was tried before Justice Beach, in New York City, and resulted in an increased verdict of $18,000 for Miss Ward.

"The hospital authorities will now probably pay the verdict, for, according to the opinions of Buffalo lawyers who have been watching the progress of this remarkably well-fought case, there is nothing on which to base another

appeal, the last case having been tried with a rigid observance of the rules of evidence, and great care having been exercised by the trial judge with a view to preventing either side from taking advantage of any errors of judgment. The main contention of the hospital was to the effect that all necessary care was exercised in the treatment of the patient; that the burns were unavoidable. The plaintiff set up that the nurse in charge of her case after the operation was an undergraduate, and therefore not wholly qualified to act. A novel proposition raised by the hospital's attorneys was that the placing of a hot water bag did not require any special degree of qualification; hence, the question of inexperience was not to be raised. The jury appears to have held, however, that the nurse was an agent of the hospital, and that the latter was therefore liable for her acts.

"There are two similar cases in Buffalo which will now either be brought to trial or settled on the strength of this verdict. In each case patients were burned more or less severely by the application of hot water bottles placed by undergraduate nurses. In one case it is stated that considerable deformity has resulted."

CANADIAN MEDICAL ASSOCIATION.

MONTREAL MEETING, SEPT., 16, 17, 18, 1902.

Below will be found a list of papers already promised for the annual meeting at Montreal in September next. Members and others contemplating contributing to the success of this meeting should notify the General Secretary at an early date of their intention. Arrrangements as to railroad and steamship rates, entertainments, clinics, etc., will be announced in due time.

"Address in Medicine"—Professor William Osler, Baltimore.

"Address in Surgery"—Dr. John Stewart, Halifax, N.S.

"Lantern Demonstration on the Exanthemata"—Dr. Corlett, Cleveland, Ohio.

Paper by Dr. D. Campbell Meyers, Toronto.

Paper by Dr. Geo. S. Ryerson, Toronto. Subject not yet decided on.

Paper by Dr. A. Lapthorn Smith, Montreal, also card specimen.

Paper by Dr. F. A. L. Lockhart, Montreal.

"On some points in Cerebral Localization, illustrated by a series of Morbid Specimens and some Living Cases," Dr. James Stewart, Montreal.

Paper and specimens by Dr. Geo. A. Peters, Toronto.

"The Country Practitioner of To-day," Dr. J. R. Clouston, Huntingdon, Que.

Paper by Dr. P. Coote, Quebec.

"The Pathologic Prostate and its removal through the Perineum," Dr. A. H. Ferguson, Chicago.

Paper by Dr. Geo. E. Armstrong, Montreal.

Paper by Dr. Ingersoll Olmsted, Hamilton.

Paper by Dr. Casey A. Wood, Chicago, "Empyema of the Frontal Sinus."

"On Tuberculosis"—Dr. J. F. Macdonald, Hopewell, N.S.

"X-ray in Cancer"—Dr. A. R. Robinson, New York.

"On Degeneration of the Spinal Cord, Anæmia, Malnutrition with Microscopic Specimens"—Dr. David A. Shirres, Montreal.

GEORGE ELLIOTT,
General Secretary.

129 John street, Toronto.

OBITUARY.

In the death of Dr. Wyatt Johnston, which occurred on the 19th of June last, not only Montreal, but the entire profession of the Dominion, sustained a severe loss. For a considerable time before he was compelled to take a private ward in the Montreal General Hospital, of which staff he was a member, Dr. Johnston had suffered from local manifestations of blood poisoning contracted in his *post*

mortem work. This eventually manifested itself in a severe attack of phlebitis, from which he was apparently rapidly recovering, when an embolus was carried to the pulmonary artery, and death immediately ensued. He was of a peculiarly retiring nature and had a most amiable disposition, which made him a universal favourite. Of his peculiar fitness to fill the important positions to which he was assigned not only in the Medical Faculty of McGill, of which University he was a graduate, but as specialist in pathological work for the Government, there was no doubt. He knew his work most thoroughly, and he did it well. His greatest discovery, and one with which his name will ever be associated, is Johnston's modification of Widal's re-action of the typhoid bacillus. The method devised by Dr. Johnston is now universally employed as the most reliable means of diagnosing this disease. His memory will remain green for many a day among his numerous friends. A good man has been cut off in the very midst of his usefulness.

PERSONALS.

Drs. Dorion and Walker (M. D., McGill, 1902), have been appointed House Surgeons to the Western General Hospital.

Mr. J. E. Morrison has been appointed Lecturer in Chemistry at Bishop's College and Assistant to Professor Donald.

Dr. George Hall (M.D., Bishops, 1896) has been appointed Lecturer in Physiology in his Alma Mater, in place of Professor Bruère resigned.

Dr. F. O. Anderson (M. D., Bishop's, 1900), sailed for Europe on the 31st July. He will visit Edinburgh and devote a few months to special work.

Surgeon-Major Elliott (M.D., Bishop's, 1889), who went to South Africa as medical officer to one of the regiments of the Mounted Rifles which sailed from Halifax early in May last, returned with his regiment, arriving in Halifax on the 29th July. We hear that he has been appointed by the Imperial authorities, Principal Medical Officer to the troops in Bermuda, for which place he has already sailed.

Dr. Alexander Macdonald (M. D., Bishop's, 1900) after filling most acceptably for over a year the position of Medical Superintendent of the Western General Hospital, has resigned to commence practice in Montreal.

Drs. McGregor and Cowley (M. D., Bishop's, 1902) have resigned their positions of House Surgeons to the Western General Hospital to become surgeons on the Elder-Dempster line of steamships. They sailed for Liverpool on the 24th July.

Book Reviews.

The Diagnosis of Surgical Diseases. By Dr. E. Albert, late Director and Professor of the first Surgical Clinic at the University of Vienna. Authorized translation from the eighth enlarged and revised edition, by Robert T. Frank, A.M., M.D., with fifty-three illustrations. D. Appleton & Co., New York, 1902.

This book has our complete endorsation. It is certainly one of the most valuable and fascinating volumes which we have seen among recent medical publications. Students, practitioners and teachers in particular are under deep debt of gratitude to Dr. Frank for giving us in the English language, one may say, the life work of such a keen observer and noted clinical teacher as Professor Albert. We have not heretofore seen any work on surgical diagnosis which can compare with it. Diseases and diseased conditions are taken up and grouped according to points of resemblance, and not according to any theoretical classification. A valuable feature in the work is the great number of interesting cases reported and followed, to the operating table, or to autopsy, either to confirm or to correct the diagnosis. The chapter on injuries to the skull and brain is specially interesting. Many cases are cited and analysed from a diagnostic point of view. The following two cases will serve as an illustration of the character of the work. Case 1, "a brick fell upon the right frontal region of a man 35 years of age. Unconsciousness for 10 minutes, followed by headache and dizziness. In four days those symptoms disappeared, but after the accident the left arm could not be properly moved. On the fourth day involuntary twitchings appeared in this arm."

In discussing this injury he says: "The rest of the history could not be quoted, but from what has been obtained it is evident that a very moderate degree of concussion had been sustained. As paralysis in the left arm followed the injury, some local lesion of the right hemisphere must have occurred. It is probable that this was situated in the upper part of both ascending frontal and parietal

convolutions. The spasms noticed on the fourth day were the result of reactive processes at the site of injury.

Case 2. A man run over by a cab was brought to the hospital without any skin wound, depressed fracture or disturbance of general condition. After six hours, paralysis, first of the left, next of the right, extremities supervened. This was followed by coma and death within three days. Autopsy showed extravasation of blood between the left parietal bone and the dura. The blood clot weighed 140 grammes and caused a flattening of the brain. The surface of the right hemisphere was bruised by *contra coup*. This case is then discussed from a diagnostic standpoint as follows:

The symptoms of paralysis increased with such rapidity that but one cause could be assigned. This cause is arterial hemorrhage, which is always rapid. It has been proven that the middle meningeal artery can rupture even without injury to the cranial bones. This rupture may occur on the side opposite to the blow, merely as a result of the momentary change in the contour of the bones. A sinus may tear, without consequent hemorrhage, but the bleeding is never as extensive. Why did the paralytic symptoms not manifest themseves at once? This fact is characteristic of injury to the middle meningeal artery. The blood must first separate the dura from the bones before it can baloon out the membranes and thus exert pressure upon the brain. As soon as this is accomplished pressure symptoms rapidly develop. But why did paralysis first appear in the left extremity when the left hemisphere was injured? With compression of the left hemisphere a right-sided hemiplegia was to be expected. Probably the contusion had previously impaired the circulation of the right hemisphere, and the pressure was therefore more readily felt in that region. Was the left hemiplegia not the result of the right-sided contusion of the brain? No, for if it had been, this hemiplegia would have appeared immediately after the injury.

F. R. E.

Progressive Medicine—A quarterly digest of advances, discoveries and improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia; assisted by H. R. M. Landis, M. D., Assistant Physician to the out-patient department, Jefferson Medical College Hospital. Vol. i., March, 1891, and vol. ii., June, 1902.

We regret that the March number only reached us at the same time as did the June number, although it was issued by the publishers on time. We have so repeatedly spoken favourably of this quarterly, that we can only affirm our previous opinion. It is particularly well-gotten up, and makes a handsome appearance on the library shelf. The March volume takes up the Surgery of the Head, Neck and Chest; Infectious diseases; Croupous Pneumonia and Influenza; Diseases of Children; Pathology; Laryngology and Rhinology; Otology. The June number takes up the Surgery of the

Abdomen, including Hernia, Gynæcology; Diseases of the Ductless Glands; the Hæmorrhagic diseases; Metabolic diseases; Opthalmology. The contributors to both these volumes are men well known in their respective fields of special research, and they have brought together, in a compact form, the latest literature on the subject.

F. W. C.

Stricture of the Urethra and Hypertrophy of the Prostate. By J. G. Freyer, M. A., M. D. M. Ch., Surgeon to St. Peter's Hospital, Lieut.-Colonel Indian Medical Service (retired). Bailliere, Tindall & Cox, 21 King William street, Strand, London, England, 1902.

In May, 1901, we reviewed this work, and now we are favoured with a copy of a new edition. That a new issue has been called for so soon is convincing evidence that it has been appreciated by the profession. This is not to be wondered at, because the author, for many years, has occupied a very distinguished position as a surgeon in the British India Medical Service. In this service he has had ample opportunity of putting to the test the many practical suggestions which his book contains. He, therefore, speaks with no uncertain sound. The style is most pleasing, and as it is not very voluminous, a few sittings will enable any one to thoroughly master its technique.

F. W. C.

International Clinics.—A quarterly of clinical lectures and especially prepared articles on all branches of Medicine and Surgery and other topics of interest to students and practitioners. By leading members of the Medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U.S A., with the collaboration of John B. Murphy, M.D., Chicago; Alex. D. Blackader, M.D., Montreal; H. C. Wood, M.D., Philadelphia; T. M. Rotch, M.D., Boston; E. Landort, M.D., Paris; Thos. G. Morton, M.D., of Philadelphia, and Chas. H. Reed, M.D.; J. B. Ballantyne, M.D., of Edinburgh; and John Harold, M.D., of London; with regular correspondents in Montreal, London, Paris, Leipsic and Vienna; volume I., 12th series. J. B. Lippincott & Co., Philadelphia, 1902. Canadian Agent: Charles Roberts, 1524 Ontario street, Montreal.

This volume contains some nineteen articles and a review of the progress of medicine during the year 1901. The first two of a series of biographical sketches of living physicians are given, S. Weir Mitchell, M.D., LL.D., and John A. Wyeth, M.D., LL.D., being the subjects. In these sketches an insight is given into the character, history, methods of working, work accomplished and literary efforts of members of the profession who stand as our recognized leaders. The elements of success are seen to be in these instances chiefly persistent and intelligent application, quick perception, self-confidence, common sense, diversity in work and conservation of strength. The biographer, Guy Hinsdale,

A.M., M.D., deems waste of time and waste of energy to be the two chief causes of failure. Photogravures are given of the men, their clinics, operating rooms, etc.

Dr. Horatio C. Wood, jun., contributes part II. on a description of the methods of investigating the action of drugs. How to study the effects of drugs on respiration, the blood and nervous system is fully discussed, accompanied with cuts of the apparatus employed.

An interesting article is that On the Significance of Basophilic Granules in Red Corpuscles, with Special Reference to Their Occurrence in Chronic Lead Poisoning, by Charles E. Simon, M.D. He traces the observation made in regard to these granules from the time of their discovery, by Marchiafava and Celli in 1884, to his own work during the last three years, giving the technique in detail. They are found mostly in cases of pernicious anæmia, malaria, myelogenous and lymphatic leukæmia and in lead poisoning. The origin of the cells and their clinical significance is discussed. The article by John C. Hemmeter, M.D., Ph.D., on Gastro-Intestinal Auto Intoxication is very instructive. Part I. appears in this volume and the subject is considered under such heads as: Nature and Concept, Terminology, Classification, Definition, Significance of the Doctrine, Criticism of Experimental Evidences, Auto-infection *versus* Auto-intoxication, Criticism of the Clinical arguments in Favour of Auto-Intoxication, Protective Function of the Liver, Causes and Types.

Other valuable contributions are: Habitual Constipation, by I. Boas, M.D.; The Climate of New England, by Guy Hinsdale, A.M., M.D.; The Treatment of Acne, by Prof. H. Hallopeau; The Surgical Treatment of Infantile Palsy, by Drs. J. K. Young and James Kelly; The Contest between the Advocates of Symphysiotomy and the Partisans of Cæsarean Section, by A. Boissard, M.D.

One-third of the volume is taken up with a review of the Progress of Medicine during 1901, by Edward Willard Watson, M.D. Besides a review of the chief advances in Medicine, Surgery, Therapeutics, Pathology, Neurology, Obstetrics and Gynæcology reference is made to the present status of X-rays, Medical Legislation, New Instruments and Devices, the eightieth birthday of Prof. Virchow and the death of President McKinley. The publishers and editors are to be congratulated upon the wisdom displayed in the character of the contributions secured, and the attractive and practical style of the contents of the present number of this popular quarterly.

J. B. McC.

The Practical Medical Series of Year Books. General Surgery. Edited by John B. Murphy, M.D., Professor of Surgery, Northwestern University Medical School. Year Book publishers, Chicago, U. S., 1902. Vol. 2.

After carefully examining this book we can recommend it, and believe it will be found of great advantage to all busy practi-

tioners. A wide range of surgery has been faithfully surveyed, and good abstracts of many valuable papers which have appeared in the surgical literature of the year have been presented. Excellent digests have also been given on important subjects by the editor. His *résumé* on appendicitis is particularly interesting, and this important disease is handled in no uncertain manner. A study of the pathology is made to indicate clearly that operative treatment is the only safe and rational practice. One is told that safety lies in early surgical intervention, and not as a *dernier resort*. The question: Should cases of general suppurative peritonitis be operated upon? must be answered by "yes." If no evidence of intense toxaemia and collapse, the quantity of pus and extent of infection do not count against operation. The non-operable cases are those where there is present meteorism, intestinal paralysis, projectile vomiting, cold and clammy extremities, anxious expression and low pulse tension. The article on diseases of the upper extremity is most interesting and important. Carl Beck's valuable paper is epitomized in which the importance of using the X-rays for diagnostic purposes is urged in all injuries in the neighbourhood of the wrist joint. Beck reports in his paper 104 cases of fracture of the carpal end of the radius (Colles fracture) which he had examined with the X-rays; 21 of these cases showed fracture of the head of the ulna as well. He points out the importance of an accurate knowledge of the exact lesion, and he maintains that frequently the X-rays is our only means of settling whether a given case is to be treated by immobilization or by massage.

F. R. E.

PUBLISHERS DEPARTMENT.