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CANADA MEDICAL RECORD

MARCH, 1900

Original Communications.

THE SYSTEM OF TRAINING MEN IN THE FIRST AID TO THE WOUNDED.

A LECTURE GIVEN BY SURGEON-LIEUT COL. CODD, R. C. D.
TO A CLASS IN "B" SQUADRON, R. C. D., AT WINNIPEG.

Officers and Non-Commissioned Officers:—

I have been requested by the officer commanding to give you to-day a lecture on the subject of "The First Aid to the Wounded," but as I lectured pretty fully to you on this particular subject last winter, I think I better term my lecture on this occasion "The System of Training Men in the First Aid to the Wounded," giving its history briefly and a few practical remarks on the subject.

The method of attending to the sick and wounded in the British Army goes back to the year 1745, and even earlier than that, but in that year Sir John Pringle, then Surgeon-General, organized a system for Regimental, Field and General Hospitals. The first appointments of medical officers and hospitals in the field was in the Peninsular War; these were under the control of Sir John McGregor, then P. M. O.

At this time there were no Ambulance Corps, in fact the assistance to the wounded in any way must have been of a most primitive nature. The improvements since, as you will observe as I proceed, are very great and of a modern nature.

In 1812 a Corps called the Royal Waggon Train was organized for conveying the sick, but this was also used for

commissariat purposes, which proved unsatisfactory in regard to helping the sick, and was consequently disbanded in the year 1833.

In 1854, at the outbreak of the Crimean War, a Hospital Conveyance Corps was organized, which consisted of non-effective men, such as pensioners, convalescents and servants. These men, however, were not properly trained and proved unsatisfactory, and disbanded.

There were other methods tried for the assistance of the wounded, but none appeared to work satisfactorily. In 1855 the first Medical Staff Corps was organized, but this again was apparently badly trained for the purpose, being at the same time employed for general hospital purposes ; this did not suit the requirements, and was done away with after a very short trial.

In connection with hospital training and nursing at this date, I must not omit to mention the valuable services of Miss Florence Nightingale, who offered her services to the War Office to proceed with her staff of thirty-eight nurses to the Crimea and nurse the sick and wounded. Her offer was accepted. Miss Nightingale and her assistants did most noble work in relieving the sufferings of the wounded soldiers, which was recognized throughout England and France by a subscription of £20,000 to found The Nightingale Home for training nurses. Miss Nightingale was, I believe, the first English lady who entered upon the work of hospital nursing, which has now become so popular in civil life and hospitals. This same year the Army Hospital Corps was established as a complete military organization ; this was the real beginning of an Ambulance System ; the members were trained for three (3) months in hospital duties before joining this Corps. Then in 1858 there was a Royal Commission, under Sir Sidney Herbert, to report upon the general sanitary state of the army and re-organize the Medical Service as well as establishing a practical medical school for training medical officers, through which all medical officers had and have now to pass for appointments in the army.

In 1873 the Regimental System was abolished and medical officers placed in one department, which system, I

presume, will be thoroughly established in our Dominion Service in the near future.

In 1883 General and Field Hospitals and Bearer Companies were established by Lord Morley, and in 1884 the officers of the Medical Department and the Army Hospital Corps were termed the Medical Staff Corps.

There is also the British Red Cross Society, an excellent organization which has for years past done great service in the wars in South Africa and other campaigns. This Society has lately permitted a branch to be established in Canada, which, no doubt, would be of great assistance to us in the event of any war.

A Volunteer Medical Staff Corps was formed in England in 1886, and is instructed by a staff from the Regular Service. There is now in London the Volunteer Ambulance School of Instruction, which is an excellent institution, and open to any medical officers who desire to qualify in ambulance work.

Then, again, there is also in England the Militia Medical Staff Corps, which was organized in 1891; they are trained annually and receive pay. The officers rank from Surgeon-Lieutenant to Surgeon-Major and Non-Coms. to that of Sergeant.

This I may say is a synopsis of the history of hospital and ambulance organization.

To be proficient in their duties, I need not tell you, it is necessary to undergo considerable instruction and training, which in this Corps involves upon me to teach you to the best of my ability and as circumstances from time to time may permit. In the first instance it is necessary for the ambulance man to understand something about the anatomy of the human body, the location of the most important internal organs and blood vessels; this will be taught you by lectures and illustrations on charts. During the present term I propose to instruct you on the anatomical outlines of the human body, the principal organs, the heart, larger blood vessels, and the circulation of the blood, the lungs and a brief description of the nervous system. You will require to know the nature of the principal wounds a soldier is likely

to receive, how to dress them and arrest bleeding. Fractures, how to treat them on the field, bandaging, what to do in emergency cases, *i.e.*, poisoning and drowning, will be taught you. These subjects are all instructive to officers as well as men. I think every officer should know something of how to act in a case of emergency, and have some knowledge of ambulance work, more especially that which pertains to the actual work on the field, such as the mode of collecting the wounded and their conveyance from the field and their disposal afterwards.

In this particular respect I might first describe briefly the medical equipment for the field in war time. This consists of field and stationary hospitals, bearer companies, ambulances, medical and surgical supplies and appliances according to the nature of the country, climate and probable length of the campaign. These would all be collected at the seat of mobilization under the charge of the P. M. O., who is responsible to the Surgeon-Major General. The P. M. O. appoints Surgeons to the different corps or units in the field ; these have charge and control of the bearer companies and ambulances placed at their disposal.

At the field hospital there is a staff of medical officers, the number being in accordance with requirements.

The stationary hospital on the line to the rear and the general hospital at the base are supplied with the medical staff proper, and are under the control of the Surgeon-Major General and the general officer commanding.

The transports necessary for hospitals, hospital supplies and conveyance of the sick and wounded to or from any distance is performed in the British Army by the Army Service Corps, but in Canada at present we have to depend on other means, generally local, for this purpose.

From the actual battle field to the base or extreme rear there is what is called three (3) lines of assistance for the wounded. The first line of assistance is that of carrying off the wounded to the collecting station. This is done by a non-com. officer and bearers under the direction of a surgeon. This station is placed in as protected a position as possible, and the wounded receive temporary relief. From here they

are conveyed by an ambulance or stretchers to the dressing station, which is placed about 2,000 yards in rear of the fighting line. Here one or two surgeons, ten men and a cook of the Medical Staff Corps are stationed. This constitutes the *first line of assistance*. From here the wounded are conveyed by rail or road in ambulances to the field hospital; which is placed beyond the range of fire. Here are stationed an ample number of surgeons and members of the Medical Staff Corps. This constitutes the *second line of assistance*. From this point those who are very severely wounded are forwarded to the base or general hospital, and others retained for a temporary time under treatment and sent back to the front. At the general hospital are the superior officers of the Medical Staff and others. Medical Boards are held here, and the wounded are either returned to the front or sent to their homes or a hospital for their future care.

In this lecture I have endeavored to give you as far as I can a fairly correct history of the organization of Hospital and Ambulance Corps, and in the latter part a description of how to handle and treat the wounded on the field. This is partly from my own experience and otherwise, which I hope may be of some use as a guide and help to the inexperienced who may in the future have to undergo the responsibilities in field work in the time of war.

PROCEDURE IN POST MORTEM MEDICO-LEGAL EXAMINATIONS.

By CHARLES A. HEBBERT, M.R.C.P., London, F.L.S.,

Lecturer on Anatomy, Faculty of Medicine, University of Bishop's College.

CASE IV.

The following case is one of presumed abortion, and is of interest as showing one of the difficulties encountered by medical jurists—that of deciding whether the death was due to criminal interference or to natural causes.

The body was that of a female, aged 26 years, 5 ft. 1 in. in height, hair brown, eyes blue, pupils dilated. The body was thin and the eyes sunken in the orbits. Rigor mortis

was present, and there was some green discolouration of the abdomen and parietes. There were no marks of external violence, and the external organs of generation were intact. A small amount of purulent fluid was escaping from the orifice of the vagina.

The skull was of medium thickness, but showed nothing abnormal.

BRAIN.—There was some injection of the pia mater, and the cerebro-spinal fluid was increased in amount. On section of the brain, the puncta cruenta were marked. The substance was firm and apparently normal.

HEART.—The pericardium was normal. The cavities were distended with black fluid blood, and decolourised clots were found among the muscoli papillares. The edges of both tricuspid and mitral valves were fringed with small recent vegetations. The muscular tissue pale.

LUNGS.—There were no adhesions and no excess of fluid in the pleural cavities. The bases of both lungs shewed pneumonic engorgement.

PERITONEUM.—The cavity contained a large amount of purulent fluid. Both the visceral and parietal layers were acutely injected and covered by a layer of fibrinous lymph. This deposit was noticed over spleen, kidneys and liver. The uterus and appendages were also coated by a similar diphtheritic membrane, more especially marked on the anterior surface of the left ovary. It was found on subsequent examination that a cyst of this ovary had ruptured externally, the edges being covered by a thick diphtheritic membrane. This was one of several cysts on the same ovary, the walls of all being lined by pyogenic membrane. The right ovary was shrivelled and atrophied.

The walls of the vagina were somewhat rugose, the mucous membrane soft and swollen, and of a dark red colour, and covered by a muco-purulent discharge. The uterus measured $3\frac{1}{2}$ in. long, 2 in. wide, the body being 2 in. long and cervix $1\frac{1}{2}$ in. The os uteri was eroded, the mucous membrane of the cavity was soft, thick and covered by a blood-stained membranous deposit on its posterior wall, the decidua, adherent to the extent of about 1 in. in diameter

The fallopian tubes were much distended and filled with pus.

The stomach was normal internally, containing some semi-digested food. The outer surfaces, as the other abdominal organs, showed signs of recent peritonitis. The mucous membrane of the intestine was somewhat swollen and softened and injected.

LIVER.—Enlarged and fatty.

KIDNEYS.—Capsules adherent, cortex diminished, shewing some cysts on the surface; both organs generally congested and dark in colour.

SPLEEN.—Much enlarged and congested.

BLADDER.—The trigonum was injected, but otherwise the walls were normal.

The reason for reporting this case is, as before said, that it is illustrative of one of the most formidable questions to be answered by a medical jurist, involving as it did in this case the liberty of a surgeon. The outside evidence was strong that abortion had been procured, and the post mortem proved that the woman had been pregnant. However, there was no sign of injury to the genital organs, and the death was distinctly due to general peritonitis set up by pelvic peritonitis, caused by the rupture of a cyst of old standing which had become purulent. That the infection had proceeded from the inflammation of the uterus was very probable, and that the inflammation of the uterus was the result of a criminal operation was open to strong suspicion; but, when the question was propounded as to whether it was directly or indirectly the cause of death, the answer had to be an uncertain one, corresponding to the Scotch verdict—Not proven.

Selected Article.

THE HOME TREATMENT OF CONSUMPTION.

By WM. OSLER, M.D.,

Professor of Medicine, Johns Hopkins University, Baltimore.

READ AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY
OF MARYLAND AT WESTMINSTER, NOV. 14TH, 1890.

In the city, from the country or from small towns, I not infrequently see persons with pulmonary tuberculosis whose circumstances are such that change of climate or life in a sanitarium is out of the question; and when we reflect for a moment on the enormous number of cases of phthisis and the trifling accommodation offered in sanatoria, the practical problem which confronts us is, how best to treat the 95 per cent. of cases necessarily confined to their homes. Cannot these poor victims reap some benefit from the recent experience of the profession?

The usual surroundings of a consumptive are only too well known to all of us. In a majority of cases the treatment is desultory, unsystematic and directed to symptoms alone. It is not too sweeping an assertion to say that of the 8,000 or 10,000 cases of consumption in the city of Baltimore to-day, few live under a definite regime. Last spring I saw in rapid succession two cases which impressed upon me forcibly the familiar fact that our theoretical knowledge of this disease has, as is so often the case, not reached a practical working basis. In a small house in South Baltimore I saw a young man, aged eighteen (one of five children), who had had tuberculosis for at least nine months. Nothing could have been more unfavorable than his surroundings, though the people were of the mechanic class, and of good intelligence. The room was stuffy, ill-ventilated, with both windows closely shut, and the temperature of the room, heated by a small stove, was nearly 80°. He had been in bed for at least three months, with much cough and a great deal of expectoration, some of which was visible on the floor, as it did not always reach the spittoon. He had high fever, loss of appetite, and was being fed on panopeptone and beef extracts. The room had a good exposure, and I suggested to the young man to have the bed removed to the window, to be well covered up, and to rest in the sunshine during part of

every day. The reply was that it would kill him, and I could see by the mother's looks that she was of the same opinion. The doctor, too, I am afraid, regarded me as a fanatic. In the same week I saw a similar picture in a different setting, a young girl who had been in bed for many weeks, with high, irregular fever and a rapidly-progressing disease. I could see that the suggestion of an open-air course of treatment was extremely distasteful, but she was induced to go to the Adirondacks, where she has done very well.

Arrest or cure of tuberculosis is a question entirely of nutrition, and the essential factor is so to improve the resisting forces of the body that the bacilli cannot make further progress, but are so hemmed in that they are either prevented effectually from breaking through the entrenchments, or, in rare cases, they are forced to capitulate and are put to the sword. Of the measures by which the general nutrition of the body may be encouraged and improved, the first and most important is:

Fresh Air.—For more than two centuries the clearer-headed members of the profession have known that an open-air life sometimes cures a case of phthisis. One of the earliest and most interesting cases of this kind is reported by John Locke, the philosopher, in his "Anecdota Sydenhamiana." "Mr. Lawrence, Dr. Sydenham's Nephew after a fever fell into a Cough, & other signs of an incipient Phthisis, (the Morbific matter being violently translated in upon his Lungs) and at length the Diarrhœa colliquativa came on: then ye Dr sent him into ye Country on Horseback, (tho he was soe weak yt he could hardly walk) & ordered him to ride 6 or 7 miles ye first day, (wch he did) and to encrease dayly his Journey as he shd be able, untill he had rid 150 miles: When he had travell'd half ye way his Diarrhœa stopt, & at last he came to ye end of his Journey, & was pretty well (at least somewhat better) & had a good appetite; but when he had staid at his Sister's house some 4 or 5 days his Diarrhœa came on again; the Dr had ordered him not to stay above 2 days at most; for iff they stay before they are recovered this spoils all again; & therefore he betook himself to his riding again, and in 4 days came up to London perfectly cur'd. The same course hath ye Dr. put others upon, especially in Pulmonick Diseases, & wth ye like Success when all things elce had fail'd him: & he was not ashamed to own yt he was fain to borrow a cure from this way now & then when he found himself puzzled with some lingering Distemper not reducible to a common & known (sic) Disease."

This reminds one of Dr. H. I. Bowditch's description of

the ride which did him so much good when as a young man he was supposed to have lung trouble.

The quality of the fresh air in our large cities may not be very good, but it is the best a large proportion of our patients can possibly get to breathe, and it is a great deal better than the atmosphere of the overheated, ill-ventilated rooms in which a majority of them live.

I give the following directions: Take the almanac and count off the hours of sunshine. In winter cut off two hours in the morning and an hour in the evening, and for the rest of the day the patient is to be out of doors. If there is no possible arrangement for life out of doors, the patient is to be in a room with a southern exposure with the windows wide open. The bed is to be moved into the sunshine. If there is a balcony or a veranda with a good outlook towards the south, it should be arranged for the patient; if not, a sheltered protection can be put up in the yard at a very moderate cost. On a well-padded lounge, covered with a couple of thick blankets, well wrapped up, the patient sits or reclines all day, coming in only to attend to the calls of nature. Only on blustering, stormy or very rainy days is the patient to remain in the house. No degree of cold is a contraindication. This continuous open-air life, at rest, is the most powerful influence we possess to-day against the fever of tuberculosis. It may take a month, it may take two or even three months before the temperature reaches normal, but it has been one of the many valuable lessons which we have learned from Dr. Trudeau, that in the fever of consumption the patient should not only be out of doors, but at rest, taking no exercise. The bedroom of the patient should be thoroughly ventilated, and the patient should be accustomed gradually to sleep with the window open.

Secondly *Food*.—The stomach controls the situation in pulmonary tuberculosis. In any long series of cases the patients who do well are those who can take plenty of food. An important cause of the lack of appetite and feeble digestion is the persistent fever, and we often find that as the temperature falls the appetite improves. It is easy to lay down rules; very hard to carry them out. Each case must be dealt with separately, but as large a quantity of food as possible should be given. Overfeeding or stuffing, when possible, should be practised, and the patient should be encouraged to pay as little attention to his subjective gastric sensations as possible. We rarely can carry out the autocratic, cast-iron method followed at Nordrach, which insists that a patient who has vomited a meal shall, *volens volens*, eat another very shortly

of the same character. For some time I have been urging the patients to accustom themselves to taking raw eggs, beginning with one three times a day, and increasing one a week until they took, if possible, twenty or twenty-four daily. For the hyperalimentation this is probably the simplest and most satisfactory diet. It has been carried out with marked success by Dr. Ely, of Rochester, who literally prescribes eggs by the dozen. Broken into the egg-cup, sprinkled with a little pepper and salt, the egg can be readily swallowed without breaking the yolk. It is most important to get the patient accustomed to taking the natural foods. Milk and cream and butter, meat and eggs and oysters should constitute the main part of the diet.

The medicinal treatment of cases may be divided into—first, the use of stomachics, bitter tonics and certain digestives; secondly, remedies such as codliver oil, hypophosphites and creasote, the benefits of which are chiefly in promoting general nutrition, and, thirdly, remedies for the relief of certain symptoms, as cough, pain, night sweats, etc.

In December last a young woman came to me from one of the towns in the State with well-marked tuberculosis. Her grandmother and two of her father's brothers had died of consumption. She had a cough off and on for three years, and for more than a year she had a great deal of fever, had lost very much in weight and had had profuse night sweats. She never had had any vomiting. When I saw her she had high fever (temperature 103°), and there were signs of extensive disease at the right apex—flattening dullness on percussion with resonant rales as low as the fourth rib. There were signs of involvement of the right apex behind, and there were a few crackling rales at the apex of the lower lobe on the left side behind. She was short of breath, and looked thin and pale. Her weight was 109 pounds. I gave her directions such as I have indicated, and she has given me a brief statement in her own words of her progress in the eleven months. She writes as follows (November 10): "When I began treatment, the first day I sat out was December 11, 1898; don't know just how cold it was, but could see the river from our porch and they were skating. In winter usually had breakfast about 8 and went outdoors about 9. When I began was not well enough to walk much, was so short of breath; after sitting out for some weeks would walk up and down porch an hour before sitting down. I spent a good deal of my time reading; became so interested in my book at times forgot how cold it was. The first two weeks I took three eggs a day, one at 10 a.m., another at 3 and an-

other before going to bed ; then six a day, two at a time, and continued to increase till I got up to fifteen a day ; continued that number for two months or more, then took twelve a day for three months, then nine. For breakfast I had oatmeal and cream and toast, or small piece of beefsteak and coffee ; dinner at 12, drank one glass of milk and ate anything that was on the table in the line of meats or vegetables (provided I liked them) ; seldom if ever eat desserts. Went out immediately after dinner and remained there until sundown ; more eggs at 3 and supper at 6 ; another glass of milk, and with that a small piece of meat, as a rule, and bread. Eggs again at 9, and go to bed between 9 and 10. Was sitting out one day when the thermometer registered 10° below zero. When it felt like snow or rain remained indoors. I kept this up till the weather was warm and then went driving, took eggs along and stayed out in country till dinner time ; drove out again late in the evening, and after my return home would sit out till after 10 o'clock. When I begun treatment had bad cough, expectorated a great deal and no appetite. The cough began to get better, and after about four months I coughed very little ; now, so rarely and expectorate so very seldom that it is hardly worth mentioning. When I consulted you last December weighed 109 pounds ; now tip the scales at 132 pounds. I have improved steadily and gained in flesh gradually from the above date."

This very practical story illustrates what could be done by many patients. Last spring I happened to be in the town in which this girl lived, and I fortunately thought of her and paid her a visit. She lived in a small two-story house, with a narrow balcony on the first story behind, and here at half-past eleven one morning I found her carefully wrapped up. She looked a different girl, and the report indicates that she has done remarkably well. At the time of my visit she was without fever, but there were still numerous moist rales at the right apex.

Since writing the above I have seen this patient (December 1), who looks remarkably well, has a good color, is free from fever, has no cough, no expectoration and weighs 133 pounds. Luckily I dictated a note on the condition of the lung at the time of her first visit, otherwise I should not have believed the extent of the change. The resonance is still impaired, the flattening is marked beneath the right clavicle, the breath sounds are harsh, the expiration prolonged, but there are only a few dry crackling rales on coughing or on deep breathing. There were no signs at the apex of the lower lobe of the left lung behind.

Two additional points of interest may be mentioned. She has not had a doctor, and she has not had a dose of medicine except an occasional dose of paregoric for the cough. She took creasote for a short time, but afterwards gave it up. shortly before she visited me her physician died, and I did not know, until my visit to her, that she had not been under any professional care. She could not have done better had she been at the Adirondacks under Dr. Trudeau.

A rigid regimen, a life of rules and regulations, a dominant will on the part of the doctor, willing obedience on the part of the patient and friends—these, with the conditions we have discussed, are necessary in the successful treatment of pulmonary tuberculosis.—*Maryland Med. Journal.*

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine
University of Bishop's College; Physician Western Hospital.

EARLY RECOGNITION OF PULMONARY TUBERCULOSIS.

KNOPF.* The negative result of the examinations of the sputum has little or no significance, since the tubercle bacilli appear in the expectorations only after disintegration of the tubercles has taken place. The use of Koch's tuberculin as a diagnostic aid is not without its dangers. This procedure sometimes causes an unexpected generalization of the latent disease, with fatal results. The etiology plays quite an important role. Man is more disposed to consumption than woman; the poverty-stricken more than the wealthy; according to some, red-haired individuals more than those having blond, brown or black hair. Vocation, age, heredity, associations, previous ailments, are all important points to be noted in the anamnesis. Coughing spells brought on by a mere change of position, or by an extra respiratory effort, hemorrhages, slight or profuse, persistent elevations of temperature, increased through exercise, loss of weight, are suspicious symptoms. Murat describes, as an early symptom, the recognition on the part of the patient of a vibration of the

* Jour A. M. A., Dec. 9, 1899.

affected portion of the lung during loud and vigorous talking. Attention must be paid to the upper air passages. Papillon's examinations with the Potain sphygmomanometer showed that an arterial pressure less than 13 cm. frequently indicated incipient tuberculosis. Chief stress is laid upon the physical examination, inspection percussion and auscultation. The agglutination process has not, in the hands of the author, yielded very satisfactory results, though he predicts for fit better results upon perfection of the technique.—*Medical Review*.

LA GRIPPE.

GILCREEST.* La Grippe is a contagious, infectious disease caused by a specific germ first described by Pfeiffer in 1892. The disease is air-borne and propagated mainly through human intercourse, as has been proven by numerous epidemics in prisons, barracks, etc. The pathologic lesions presented by uncomplicated la grippe are of a character common to all infective diseases, *i. e.*, parenchymatous degeneration of various organs. There are three distinct forms of la grippe: 1. Simple without complications. 2. Complicated with serious pulmonary affections. 3. Complicated with digestive and nervous symptoms. The complications are innumerable, including affections of the eye, ear, lungs, pleura, heart, genito-urinary tract, etc. Farson has observed an increase in the number of cases of appendicitis during grippe epidemics. The author reports two cases of the severe nervous type, both of which are recovering. We have no specific for la grippe, so that each case must be treated symptomatically with reference to the complication. "To allay pains and soreness and restore free elimination from the skin, kidneys and intestines, are the indications which should guide us in our therapeutic applications."—*Medical Review*.

A NEW METHOD OF TREATMENT WITH MERCURY.

A. BLASCHKO.† On the theory that mercury, when applied to the skin, finds its way into the organism through the process of inhalation, Blaschko undertakes to reach this end by a specially prepared mercurial preparation, which does not have the disadvantages of the grey salve. The preparation is a sort of cotton cloth, which is impreg-

* Jour. A. M. A., Dec. 9, 1899.

† Berl. klin. Woch., Nov. 13, 1899.

nated with a 90 per cent. mercurial salve. This is called mercolint. The material is so well prepared that no trace either of the salve or of the mercury can be observed. Shirts are made of this material, which the patient wears next to the skin day and night. When the shirts become white, which takes about four weeks, the mercury has all been absorbed. These garments can be made of varying strength up to 50 per cent. mercury. The author has used this means of giving mercury in his clinic for some time with gratifying results. The advantages of this method over the inunction cure are obvious. Especially is it advantageous in small children and babies, pregnant women, etc. Such shirts can be worn for many months, and would save the patient repeated inunctions cures, with all their discomfort and disadvantages.—*Medical Review*.

DRY HEAT OF HIGH DEGREE AS A THERAPEUTIC AGENT.

C. E. SKINNER* has employed dry heat, up to 500° F., in the treatment of various diseases. The apparatus used and the exact method of its application are fully described, together with the report of a number of cases showing the mode of procedure in each affection. He has found that hot air is a pain-relieving agent of unequalled value in those conditions where its application is indicated and possible, because of its constant effectiveness, rapidity of action, and the absence of deleterious after-effects. In rheumatism its action is so profound in connection with judiciously chosen drugs that it may almost claim a positive curative power of its own, and may be said to be the most powerful contributory agent we know. It is capable of stimulating tissue repair to a remarkable degree, as is demonstrated by its effect upon sprains. It is capable of influencing most happily septic inflammation of serous membranes, as shown by its action in peritonitis and pleurisy. It will many times at least give us the power of economizing nervous energy by relieving pain and other more or less dangerous conditions in pneumonia, thereby enabling us to refrain from sedatives and cardiac stimulation, and thus save for the patient nervous energy, which will sometimes be sufficient to tide him over a crisis by which he would otherwise be overwhelmed. The addition of hot air to our armamentarium will enable us to increase by a large percentage the sum total of our power over disease.—*Medical Review*.

* N. Y. Med. Jour., Oct. 28, Nov. 25, Dec. 2 and 9, 1899.

TREATMENT OF TAPEWORM BY USE OF MORPHINE INJECTED INTO THE PROTRUDING PART OF THE PARASITE.

By J. W. KIME, M.D.,

Editor *Iowa Medical Journal*, Keokuk, Iowa.

The attempt at removal of tapeworm by any of the tænicides is followed by a large number of failures which, by the method which I have used in two recent cases, might be converted into successes.

It is a very common occurrence for the parasite under such circumstances to drop down into the lower part of the intestine and reattach itself with the sacrifice of a considerable portion of its caudal extremity. I have sometimes been able, by copious injections of water or saline solutions, to bring away the head of the worm, but far more frequently have I succeeded only in breaking off the worm.

Recently it occurred to me, while attempting to remove one of these pests, fifteen feet of which were visible and ten feet invisible, that I might take advantage of the latter portion by properly medicating the protruding part. I therefore, after tying a string moderately tight around the worm about three inches below the patient, injected above the string, directly into the substance of the worm, one-half grain of morphine; the protruding part was then severed with scissors just below the ligature, and the three or four inches remaining were passed up through the sphincter there about ten minutes.

A large injection of water was then given, and the upper portion of the worm passed entirely motionless and apparently dead.

Since reporting this case in the *Iowa Medical Journal* I have treated one other case the same way, and with the same results.

Most varieties of tapeworm have a pair of longitudinal vessels passing from one extremity to the other, through all the segments, and toxic substances injected into the body of the worm are taken up by them and reach every portion of the parasite.

The mistake is often made of simply prescribing some remedy with directions for the patient to use. Only a small percentage of successes can thus be expected.

The only proper method of treating tapeworm is about as follows:

The patient does not fast or have any preparatory treatment whatever, except that he eats no breakfast on the morning of the day of treatment. At about 9 a. m. he is given a dose of infusion of pomegranate, or what is far

better, of tannate of pelletierine, with one or two drops of croton oil. The patient should be kept at rest, generally under the personal observation of the physician, for two or three hours, when movements of the bowels will most likely occur and the whole or part of the worm be passed. If only a part protrudes, then the hypodermic should be used as above described.

LACTATION IN A MALE INFANT.

G. M. Blair reports the case of a boy with highly developed mammæ as large as a walnut. Pressure caused milk to exude. The external genitals were normal except that only one testicle appeared in the scrotum. The child's general condition was bad, and he suffered from vomiting and emaciation.

REMOVAL OF A HAT-PIN FROM THE STOMACH.

J. Halliwell reports the case of a woman, aged sixty years, who accidentally swallowed a hat-pin about four and a half inches long. It was removed by abdominal section four days after. Operative details and recovery were without unusual features.

THE PREVENTION OF HAY FEVER.

Dr. Alexander Rixa, a noted physician of New York, has contributed an article to the Journal of the American Medical Association upon the Prevention of Hay Fever, which just at this time ought to be of much interest to our readers. The practical part of the paper is the prophylactic treatment of the nasal passages of those subject to this recurrent disease. About two weeks before the ordinary time of attack the patient must begin with some antiseptic, and Dr. Dixia believes that Hydrozone, a most innocuous and powerful germicide, being three volume of peroxide of hydrogen, is best. To begin with he uses in the proportion of 1 to 12 sterilized water, increased to the strength of 1 to 4. In most obstinate cases, when there is still some irritation in the nasal cavity, I give as an adjuvant the following prescription :

R Acid borax, gr. xx.
 Menthol, gr. iv.
 Glyco-thymoline, \bar{s} ij.
 Sol. eucain B. 4 per cent., q. s. ad \bar{s} ij.
 Sig. Use in atomizer.

As a rule this treatment was sufficient to subvert the disease and keep the patient in comfort.

SURGERY.

IN CHARGE OF

ROLLO CAMPBELL, M.D.,

Lecturer on Surgery, University of Bishop's College ; Assistant-Surgeon, Western Hospital ;

AND

GEORGE FISK, M.D.

Instructor in Surgery, University of Bishop's College ; Assistant-Surgeon, Western Hospital

SOME PRACTICAL NOTES ON DISEASES OF THE RECTUM.

L. H. Adler, jr., refers briefly to some practical points in the consideration of some of the forms of rectal diseases. Congenital malformations of the anus and the rectum occur often enough to justify attention being called to the necessity for every new-born child being carefully examined at the time of its birth. In the treatment of suppurative process in the neighborhood of the rectum, poultices should be avoided and the affected parts laid freely open as soon as the formation of the abscess is recognized, even before pus is present. In all cases of fistula in ano it is to be remembered that the sinus may be the result of a stricture of the rectum, and the usual treatment directed for the relief of the fistula will not result in a cure. A digital examination of the bowel will usually prevent such an error being made. In cases of fistula the internal opening in most cases is to be found between the two sphincter muscles and not higher in the rectum. In the treatment of fissure of the bowel the use of opium should be avoided ; the best remedy is iodoform, preferably in the form of a ten-grain suppository, of which one should be carefully inserted into the rectum half an hour before an expected movement of the bowels and another immediately after the passage has occurred. All hemorrhoids do not require operative interference ; in the formative stage frequent ablutions of the part with cold water will allay, if not abort, inflammatory tendencies of the veins, which otherwise finally lead to piles. Operation should not be postponed until the acute inflammation has subsided ; it is when the patient is suffering that consent will be most readily obtained, and it is owing to such advice that patients finally drift into the hands of quacks.—*N. Y. Med. Jour., Medical Review.*

FOR THE REMOVAL OF FOREIGN BODIES FROM THE NOSE AND EAR.

Sturrock (*British Medical Journal*, November 25, 1899, p. 1473) recommends the following mode of procedure: The presence and approximate situation of the foreign body having been ascertained, a piece of india-rubber tubing, rather less in diameter than an ordinary lead-pencil, varying in length from one to three inches, and attached to the nozzle of a brass syringe, is introduced into the nostril or meatus, as the case may be, and brought into contact with the foreign body. The piston of the syringe is then pulled out for a sufficient distance to create a vacuum in the tubing, and thus to draw the foreign body into or against its free end. The syringe is then withdrawn and with it the foreign body attached to the tubing. In some cases it has been found advantageous to dip the tubing into glycerin before insertion, in order to diminish the chances of air entering between the tubing and the foreign body.

DEVICE FOR WASHING OUT THE PELVIS OF THE KIDNEY.

L. B. Tuckerman, in the *Cleveland Medical Gazette* for July, 1899, has devised a simple method of irrigating the pelvis of the kidney. It consists of a No 6 French catheter, an ounce bulb, and a common exploring aspirator with the ordinary three-way stop-cock, all connected by rubber tubing. The catheter is introduced in the ordinary manner through the Kelley speculum. It is necessary to use a stylet in the catheter, passing the catheter up as far as possible without force, then withdrawing the stylet a couple of inches, passing the catheter farther, and so on, until the pelvis of the kidney is reached; then by exhausting the contents of the pelvis of the kidney, they can be drawn into the bulb and inspected. From the amount of fluid which is drawn into the bulb we may judge of the capacity of the pelvis of the kidney. If pus, and it be deemed advisable to wash out the kidney, the bulb can be detached from the catheter, filled with boracic acid solution or such other disinfecting fluid as the practitioner may deem best, and, by reconnecting and reversing the stop-cock, the fluid can be injected into the pelvis of the kidney, again withdrawn, until, as in washing other cavities, the fluid comes away clear. To medicate the pelvis of the kidney, the bulb can be filled with the proper quantity of medicament, which in its turn is forced into the pelvis of the kidney where it is left by the withdrawal of the catheter.

This device the author has used recently in the case of

a woman afflicted with pyelitis, with the right kidney plainly palpable. The right ureter was occluded, or nearly so. In two sittings he succeeded in passing a catheter up to the pelvis of the kidney, and in the third sitting dilated the ureter to No. 8 French. From the pelvis he exhausted an ounce of pus, washed with boracic acid as above described, and filled the cavity with a one-per-cent solution of ichthyol. At the next sitting the ureter was found unobstructed and the capacity of the cavity of the pelvis of the kidney reduced to about three drachms. The patient is a hopeless case so far as a cure is concerned, as microscopic examination of the pus from both ureters shows tubercular bacilli, but she was improved after the washing out of the kidney. In a case of pyelitis of gonococcal origin, it seems rational to treat the pelvis of the kidney by flushing.—*Medicine.*

GOITRE.

It has been my opinion for some years past that iodine alone was the essential medical remedy for the removal of such goitres as could be influenced by medicine, and with this idea in mind I have, during the last four years, treated three-fifths of my cases with iodine and two-fifths with the thyroid preparation, and have found in thirty thus treated that the patients who received the iodine improved more rapidly than the others, and during the last three months my patients have been taking iodine, only accompanied by tonics as required. Few of them can take iodine steadily for many weeks, without showing evidence of weakness; slight anæmia is likely to follow, with increased rapidity of the heart's action; often slight dyspnœa and headache with diminution of bodily weight. The prescription is as follows:

R Iodi (crystals)..... gr. ij.
 Pot. iodid gr. iv.
 Spir. vini rect..... ʒ i.
 Syr. simplicis..... ʒ i.
 Aquæ destill..... ʒ ij.

M. S. A teaspoonful in a wineglassful of water one hour after each meal time.

After about two weeks, sometimes from the beginning, an iron tonic is given; and, if the patients are weakening rapidly, strychnine combined with calisaya and iron, the iodine being discontinued for a week or two at a time. After three weeks there is usually a perceptible difference in the size of the goitre. In six months many of the goitres disappear, others are reduced to from one-half to one-eighth their original size.

—FREDERICK G. SCHAEFER (*Journal of the American Medical Association*, November 25th).

THE EARLY DIAGNOSIS OF TUBERCULAR JOINT DISEASE.

L. W. Ely, in the *Medical Record* of December 16, 1899, says that the late recognition of tubercular disease of a joint is comparatively simple, but an early diagnosis is essential if the case is to be cured with a return of function. In no class of disease does the axiom that the eyes should be used first and most and the hands last in diagnosis apply so well as in these affections. A good history is needed also in arriving at certainty in diagnosis. Tubercular disease is usually characterized by gradual development, and the beginning cannot be, as a rule, definitely fixed. With slight ameliorations it gradually grows more severe; there is frequently a history of trauma. Pain and stiffness are two important symptoms. Pain is rarely located in a certain spot, but in indicating it the hand is usually passed over a certain region. It is worse on motion, and is apt to come in paroxysms at night, when the muscles holding the joints quiet are relaxed. Stripping the patient is of the utmost importance; this rule knows no exception in men and children, and in women it should be modified but slightly. Next, the attitude should be observed, then the deformity and change in contour.

The joints most liable to tubercular disease in the order of frequency are the spine, hip, knee, ankle, elbow, wrists, and shoulder. This study is based on 453 cases of tubercular joint disease observed at the Vanderbilt Clinic between January 1, 1895, and January 1, 1899. The history of these cases was negative in 309, in 76 heredity is not mentioned, but in 68 a positive tubercular family history was obtained. Sacroiliac disease, of which much has been written, is very rare; but one case appears on the record of the Vanderbilt Clinic for four years. The author considers the symptomatology of tuberculosis in the joints.—*Medicine.*

THE WAYS OF TREATING GONORRHEAL JOINTS.

It will be admitted by most physicians and surgeons that the treatment of gonorrhoeal joints is most unsatisfactory. The diagnosis is not always clear, but practitioners of experience will generally bear out the assertion that the sudden development of inflammation in a single joint, if accompanied with a urethral discharge, or even if the latter has been for some time suppressed, is sufficient to induce a strong presumption of the specific character of the inflammation. Two lines of treatment seem to offer fair results. One is strictly

surgical, and consists of immediately opening the synovial membrane under, of course, the most approved antiseptic precautions, allowing the joint to drain, or, if necessary, washing out the joint cavity, providing it is infected. Another is that recommended by Christian Heath, who immediately places such patients in bed, applies belladonna and glycerine freely to the affected joint, and gives quinine in five-grain doses every six hours. He does not use splints, and pays no attention to the urethral discharge.—*Medical Review*.

OBSTETRICS.

IN CHARGE OF

H. L. REDDY, M.D., L. R. C. P., London,

Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

PRECOCIOUS MENSTRUATION.

E. Perier mentions a child which began to menstruate regularly at 9 months of age. When seen three months after menstruation commenced, the breasts were well formed, nipples protruding, pubes covered with hair, and labia majora and minora well developed.

HYPEREMESIS GRAVIDARUM.

Dirmoser believes that auto-infection from the intestinal tract is the usual cause of hyperemesis, and that the etiological importance of hysteria is largely over-estimated. He refers to the similarity of post mortem changes in hyperemesis and acute infection. Urinary analysis shows an increase of indol, skatol, and other products of retrograde metabolism, also albumin, acetone and peptone. Organic structural elements are found in the urine, indicating a nephritis. There exists an individual predisposition, probably owing to the abnormal condition of the intestinal canal. The best treatment for this obstinate and often serious complication of the pregnant state would be intestinal antiseptics, and the author states that the results obtained from such treatment will be published at a later period.

AMNIOTIC INFECTION BEFORE RUPTURE OF THE MEMBRANES.

Lehmann reports a case of undoubted infection of the liquor amnii before rupture of the membranes. A thick and extremely fetid fluid escaped as soon as they were artificially punctured.

SEPSIS AS A CONTRIBUTORY CAUSE OF PUERPERAL INSANITY.

BRUSH, *American Med. Quarterly*, limits his paper to the consideration of insanity of the puerperium. Numerous statistics show that of cases of insanity in asylums, some six or seven per cent. date from insanity of the puerperal period proper. However, many of these cases come from psychopathic stock, childbirth acting only as an exciting cause. If heredity is one fundamental attribute, Brush appears to believe that sepsis is the other ; that is, whenever hereditary can be excluded, we must look upon the case as having had a septic causation.

Obstetricians of by-gone generations, such as J. Y. Simpson and George T. Elliot, were believers in the toxic origin of puerperal mania, which is not very remote from the idea of sepsis. The most striking document in favor of the sepsis theory is brought forward by Chapin, the alienist, who states that since the introduction of antiseptics in midwifery, there has been an enormous falling off in the number of cases of puerperal mania. A similar falling off has been reported from several insane asylums, although no such decline was observed at the McLean Asylum, in Somerville, Mass. The writer finds that the type of delirium exhibited in most cases of puerperal mania agrees with that form which accompanies intoxications. This is especially true of the early weeks of the disease. A case is given in which the mental symptoms are shown to be rather of the nature of the delirium of acute infectious diseases with its lucid moments, its noisy incoherent ravings, auditory and visual hallucinations, together with the quick pulse, dry, brown tongue, sordes, etc. The condition, however, goes on indefinitely, while always preserving something of the stamp of simple delirium.—*Obstetrics*.

TRANSMISSION OF STREPTOCOCCUS FROM MOTHER TO THE FETUS.

Bonnaire reports two such cases. In the first the mother was suffering from erysipelas at the fifth month of pregnancy. The membranes had been ruptured three days and putrid liquor amnii was discharging. The fetus was expressed and died forty-eight hours later. Cultures of its blood showed the streptococcus only. In the second case the mother gave birth to a dead child just before she succumbed to cerebro-spinal meningitis. Autopsy showed pus over the cerebral and spinal meningitis, and exactly the same lesion in the fetus. Cultures from both showed streptococci cultures of the blood were negative.

TUBERCULOSIS AND PREGNANCY.

Lambinon (*Fourn. d'accouchements*, Sept. 24, 1899) gives a brief compilation of the present state of our knowledge of this association. In 1895 Charrin insisted that the toxins in a pregnant woman suffering from an infectious disease would necessarily affect her progeny; this being especially true of tuberculosis and pneumonia. Children born under these circumstances gain in weight very slowly.

However, the fact has been cited that in orphan and foundling asylums hereditary tuberculosis (which in theory ought to occur more frequently than in children of the living), does not cause an increase in the natural morbidity of childhood in general.

But it is undeniable that now and then a case of undoubted congenital tuberculosis is reported. Lehmann, Doleris, and Bourges and others have published well-attested cases of this sort, explicable by no other hypothesis than intrauterine infection.

Bar and Renon, Schmorl and Birsch and others have found bacilli in the blood of the umbilical vein in cases in which the mother was in a moribund condition from tuberculosis.

Lambinon, however, looks upon such cases as medical curiosities and exceptions which proved the rule. Practically the child of tuberculous ascendants is not exposed to the action of either the bacillus or its toxins. It may inherit a delicate organization, such as would readily fall a prey to tuberculosis, but that is all. A child born of a tuberculous mother should be separated from her immediately after its birth.

NURSING BY ALBUMINURIC WOMEN.

P. Budin and Chavane have observed five albuminuric women immediately after delivery and four during the months following labor. All of these nursed their children without any unfavorable results to the infants themselves. The albuminuria frequently disappears rapidly, and in any event does not delay convalescence.

OBSERVATION ABOUT SORE NIPPLES.

According to Platzer sore nipples are caused through biting and pulling, during the process of nursing. The best treatment of fissures are applications of carbolic acid solution. Ulcerations should be washed with corrosive sublimate solution and dusted with dermatol. In mastitis nursing

must be interrupted, the breast compressed and ice bags applied. Among 1000 nursing puerperæ in Kermarsky's clinic, sore nipples were observed in 51.5 per cent.

PROPHYLAXIS OF ECLAMPSIA.

Knapp emphasizes the fact that eclampsia appears often in quasi-epidemics—*i. e.*, there are occasions upon which, for some unknown reason, this affection is much more prone to occur than otherwise. Our prophylaxis, however, is restricted to cases which exhibit edema of the eyelids, skin of abdomen, vulva, legs, etc., and in which albuminuria is present. There are certain cases in which these gross features are absent, and in which there is only a persistent malaise ; such cases may lead up to an "eclamptic aura" and convulsions. In the classes just enumerated, then, we have definite prophylactic indications.

But there are other cases in which everything appears to be progressing favorably toward a successful parturition. Suddenly there set in headache, nausea, vomiting and gastralgia. There is a general sense of discomfort, psychical excitability, and a train of nervous symptoms which herald the early appearance of convulsions. To foresee a possibility of eclampsia in cases which are devoid of advance signals, a careful testing of the retina and field of vision should be undertaken.

Broadly speaking the prophylaxis embraces avoidance of psychical disturbances, avoidance of dietetic errors, and protection from exposure. To secure these ends we must insist upon rest in bed (complete), exclusive diet of milk with diuretic waters (lithia), alvine evacuations secured artificially if necessary. To secure diuresis we must be prepared to resort to the salt solution. If there are actual renal lesions, as shown by the presence of marked edema, hot baths and the hot pack are indicated. As eclampsia is synonymous with convulsions we can no longer speak of prophylaxis after the first convulsive seizure has occurred.—*Obstetrics.*

TREATMENT OF PUERPERAL INFECTION.

A. W. W. Lea draws the following conclusions from a series of 48 cases. A rise of temperature over 101.4 during the puerperium, not obviously accounted for by other causes, should lead to a thorough examination of the genital tract. If no explanation is found, a uterine douche should be at once given. If the temperature falls definitely within twenty four hours, no further explanation is necessary. If, on the other

hand, the temperature remains high, and the pulse rate has increased, the cavity of the uterus should be explored with a sterile finger. When the initial temperature is great (103 or over) the uterus should be explored at once. When clots or placenta are discovered, they should be removed by the finger or curette, a douche given, and a gauze drain inserted for twenty-four hours. There is no evidence that curettage, if done with every precaution, favors the spread of infection. In a large proportion of cases the infection is rapidly checked. When there is a very virulent infection early curetting affords the best chance of a successful result. If curettage entirely fails, it must be repeated or not, according to the local conditions present. The prognosis, however, is bad. In some cases if curettage fails, and there is no evidence of general peritonitis or infection of the blood, vaginal hysterectomy, if performed in good time, may be successful. Anti-streptococcic serum should be given early and freely in cases of proved streptococci infection. It is of little use in the advanced stages of the disease.

THE TREATMENT OF THE VOMITING OF PREGNANCY AND PHTHISIS BY OXYGENATED WATER.

Gallois (*Sem. Méd.*) has used oxygenated water in the vomiting of pregnancy for the last three years, and has had only two cases where it failed to cure. This treatment has no effect on ordinary gastric vomiting, but Bonnel has had excellent results with it in the vomiting of tuberculous patients. It is doubtful how it acts; partly, perhaps, by giving up its oxygen, and partly by neutralising the toxic properties of some ptomaine.

INFLUENCE OF PREGNANCY UPON THE TEETH.

Terrier states that caries is more rapid in its advance, that the sensibility and friability of the teeth are increased, that their chemical composition is altered during pregnancy. These changes are caused by gingivitis of pregnancy, alteration of saliva, acid regurgitations from the stomach, general modifications in the digestive and in the urinary apparatus, and increased excitability of the nervous system due to pregnancy. He urges careful cleansing of the teeth and treatment of caries and gingivitis early in pregnancy, while the daily care of the teeth should be continued through pregnancy and lactation.

Therapeutic Notes.

SCARLET FEVER.

J. Lewis Smith recommends the following "diaphoretic, diuretic, and laxative" mixture for scarlatinal nephritis:

℞ Potassi acetatis	
Potassi bicarbonatis	
Potassi citratis, āā.....	ʒ ii
Infus. tritici repentis. ad.....	ʒ viii

A teaspoonful every three or four hours for a child of five years.

Whitla gives the following diaphoretic mixture for the early stages of scarlet fever:

℞ Spiritus ætheris nitrosi.....	ʒ ii
Potassi citratis.....	ʒ i
Liq. ammon. acet.....	ʒ iss
Syrupi simplicis.....	ʒ i
Aquæ camphoræ, ad.....	ʒ iv

M. Sig. A teaspoonful every three hours.

Widerhofer recommends the following for scarlet fever, with throat affection:

℞ Potassi chloratis.....	gr. xx
Syrupi aurantii.....	ʒ iii
Decoct. cinchonæ, ad.....	ʒ iii

M. Sig. A teaspoonful every two hours.

THROAT SPRAY.

Whitla uses the following spray for the throat in scarlet fever:

℞ Glycerini boracis	ʒ iv
Glycerini acid. carbolicum.....	ʒ iii
Aquæ rosæ, ad.....	ʒ x

SKIN LOTION.

J. Lewis Smith recommends the following lotion for the itching of the skin in scarlet fever:

℞ Acidi carbolicum.....	ʒ i
Tinct. camphoræ.....	ʒ ii
Aquæ puræ.....	O i

M. Sig. Shake well, and apply over surface when needed for pruritis.—*Year. Am. Med. Association.*

TO CURE ITCH IN TWO HOURS.

R Sulphur	3 ounces
Quicklime.....	6 ounces
Aquæ.....	2 pints

Boil till combined, then allow to cool and settle ; decant and keep hermetically sealed.

Sig. Rub with soft soap for half an hour, then take tepid bath for half hour. Then apply solution and leave on for quarter hour, then take bath.—*Med. Age.*

Dr. Whitla, in the *Therapeutic Review*, says that one of the best combinations in the treatment of baldness consists of :

R Pilocarp. hydrochloratis.....	gr. v
Otto rosæ.....	ʒ viij
Ol. rosmarini.....	ʒ iv
Linimenti cantharidis.....	ʒ iv
Glycerini puri.....	ʒ j
Ol. amygdalæ dulcis.....	ʒ ij
Spts. camphoræ.....	ʒ ij

M. Sig. To be rubbed well into the scalp, night and morning.

HEBRA'S CORN CURE.

R Acid salicylici.....	gr. 15
Ext. cannabis indicæ.....	gr. 8
Alcoholis.....	ʒ 14
Ætheris	ʒ 40
Collodii flx.....	ʒ 75

M. Sig. Paint on thrice daily for one week ; then soak the foot in hot water and pick out the corn.—*Medical Record.*

Jottings.

Chloride of sodium is strongly recommended by Perkins, who claims to have used it in every case of ringworm that has come under his observation for the past sixteen years, and in no case did it fail to give relief. In one of these the disease had been of five years' standing, and the cure only took three weeks. The chloride of sodium in fine powder is rubbed up with vaseline to make a moderately stiff oint-

ment. The affected part, if covered by hair, is shaved, and the ointment is thoroughly rubbed in night and morning. In a few days the part becomes inflamed, after which a simple emolient is applied. Two daily applications of the ointment for three or four days is usually sufficient to destroy the parasite over the area to which it is applied. The simplicity of this method makes it particularly desirable, and it would be interesting to know if other observers reach similar results. There is a possibility that in our search for new and rare chemicals as antiseptics that we are overlooking some efficient and well-known older remedies.

The following method of treating chlorosis was advocated by Sir Andrew Clark. With careful attention to the diet and a tepid sponge bath, followed by brisk toweling night and morning, he prescribed the following mixture:

R	Ferri sulphatis.....	gr. xxiv.
	Magnes. sulphatis.....	ʒ vj.
	Acid. sulph. aromat.....	ʒ j.
	Tinct. zingib.....	ʒ ij.
	Infus. gentian. comp. vel quassiā q. s. ad.	ʒ viij.

M. Sig. One-sixth part twice daily, about 11 and 6 o'clock.

Occasionally this acid mixture produces sickness, dries the skin and is otherwise ill-borne. In such cases he prescribed the following alkaline mixture:

R	Ferri sulphatis.....	gr. xxiv.
	Sodii bicarb.....	ʒ ij.
	Sodii sulphatis.....	ʒ vj.
	Tinct. zingib.....	ʒ ij.
	Spt. chloroformi.....	ʒ j.
	Infus. quassiā q. s. ad.....	ʒ viij.

M. Sig. One-sixth part twice daily, at 11 and 6 o'clock.

Sometimes neither mixture agrees with the patient, in which case he prescribed sulphate of iron pill with meals, and a saline aperient on first waking in the morning. By this plan Clark held that nine out of ten cases recovered in from one to three months, and by careful attention to the bowels, taking twice a week a pill composed of aloès, myrrh and iron, the recovery probably would be permanent.—*Practitioner*.

The *Medical Press and Circular* says: "When there is a frequent desire to pass water in elderly or nervous women, or it runs away in the act of coughing, sneezing or laughing, it is generally due to want of power in the vesical sphincter. In such cases the tincture of cantharides will be found of the greatest service if given in small doses of one minim in water three or four times a day."

INDIRECT CAUSE OF COUGH.—The *Charlotte Medical Journal* gives the timely advice: "Always search well for the cause of a cough. There are frequently cases of chronic cough which have resisted all the usual remedies at the hands of the physician, and which he in desperation practically gives up when he advises the patient to change climate or take a long sea voyage, when, if greater care were taken in searching for the cause by the process of exclusion, he would cure his patient. The relaxed or elongated uvula is a frequent cause. Stringy tenacious mucus hanging from adenoids in the naso-pharynx is a great cause in children. Not infrequently foreign bodies in the external meatus are responsible; this reflex cough is readily demonstrated by passing a probe along the floor of the meatus, which will, as a rule, cause a tickling in the throat. An otitis media discharging pus through the Eustachian tube into the pharynx is not to be lost sight of. Hypertrophy of the lymphoid tissue at the base of the tongue constituting the lingual tonsil when it presses upon the side of the epiglottis or the anterior pillar of the pharynx is a cause of cough not often thought of."

ENURESIS.—Dr. M. G. Price (*Louisville Four. Surg. and Med.*) claims to have had much success with this rebellious trouble, and gives below one of the remedies used by him:

R	Tinct. belladon	gtt. v
	Ext. ergot fluid.....	gtt. x
	Tinct. nucis vom.....	gtt. v

M. Sig. Repeat four times a day.

BORIC ACID SUGAR FOR THRUSH.—Escherich states that the promptest and most effective method of curing thrush and cleansing the mouth is to put a little boric acid and saccharin on a sterilized rag and give it to the infant to suck.—*Four. Am. Med. Association.*

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Editorial.

MEDICAL OFFICERS AND THE CANADIAN MILITIA.

The various Infantry Battalions forming the Canadian Active Militia, up to the present time, consist of from four to eight companies, with one or two of ten companies. The strength of the eight company Battalions is in the neighborhood of three hundred and sixty-eight of all ranks; one, however, viz., the 1st Prince of Wales Fusiliers, has an authorised roster of six hundred and sixty-eight. These facts at once show that they are all skeleton Battalions, with a complement of officers sufficient to run it when made up to its war strength of one thousand men. The regimental system of medical officers has been, and practically is, the one now followed. A Surgeon-Major and a Surgeon-Lieut. or Captain appeared on the strength of each Battalion up to 1894, when Major-General Herbert, in making up the establishment list, dropped the Junior-Surgeon as unnecessary. This action was resented by Commanding Officers, as being injudicious, as it removed an officer who contributed to expenses, which unfortunately are high. When Major-General Gascoigne assumed command of the militia this Junior

Medical Officer was replaced—but without pay—unless in camp, and then he was to do duty only at alternate camps. There is no doubt that alone, regimental medical officers are inadequate for the duties required during a period of active service in the field. Great Britain found this out during the Crimean War, and the Army Medical Department, now the Royal Army Medical Corps, was the result of this experience. There were, and are, peculiar difficulties to be faced in our Canadian Militia, and though, as we will shortly show, a change will soon come, it will be, and perhaps wisely, in a modified form. To Lieut.-Col. Neilson, Director-General Medical Staff, to which position he was appointed rather more than two years ago from the Royal Canadian Artillery, is due a scheme which has much to commend it. He contemplates forming Bearer Companies at all the large garrison depots, with field hospitals on the line of the British service; also a medical staff. He, however, retains the Senior Surgeon, but removes the Surgeon-Lieut. from the regimental strength, and gives them the option of joining the medical staff, with a rise in rank. All others joining take rank as Lieutenants, with promotion after a stated service. Under ordinary circumstances, such a strength is amply sufficient for all camp duties. The embodiment of the active militia is, however, with a view of having a nucleus ready for augmentation on a declaration of war. Within a few weeks after such a declaration, we should have in the field a force of at least one hundred thousand men or more. For such a force the proposed scheme would, we feel sure, prove utterly inadequate. It may be argued that if war ever takes place in Canada, it will be due to an imperial cause, and, as we would be joined by a large imperial army, so would the direction of medical matters come under the Royal Army Medical Corps. But events in South Africa have proved that this corps is very weak in numbers, and quite inadequate to perform the duties it has been called upon to perform. Forty years ago the British Army and Militia Medical Staff together numbered about 1,350 officers, and at the moment they have sunk to under 900. This has been largely brought about by allowing the Militia Regimental

Surgeons to disappear, by death and age retirement. That process has gone on so steadily that, from a former total of about 250 Militia Regimental Medical Officers, they have sank to a poor remnant of 24, most of them well on in years, and naturally soon to follow their retired brother officers. The result of this condition of things is, now that Britain has made a heavy call on her militia, the Government find themselves without their former Militia Regimental Medical Officers; and with the Army Medical Corps fully occupied, is unable to assign few or any of them to Militia Battalions. The result of this condition of things is, that a host of civilians are being recruited, so to speak, to take their place. A similar state of things exists at the seat of war, where nearly two hundred civilians are now employed. Any one who has had any experience of military life knows that the duties of a Military Medical Officer cannot be learned in a few weeks. Moreover, military medical duties are a species of specialty, and while the civilian medical man is learning them, the corps to which he is attached suffers in no small degree from this want of knowledge. Army officers well know that in any campaign the civilian element becomes a great source of weakness. We readily admit that a unified medical service has conserved force and thereby lessened expenditure, but it would seem as if the theory has been carried to such an extreme in practice as to strike at the root of the efficiency. The present war in South Africa has exposed the evil, and the day of reckoning has arrived. British medical men are loudly clamouring, both for a large increase of the Royal Army Medical Corps and a possible revival of the Regimental Militia Medical Service, or a combination of both. The lesson which we in Canada should draw from the present condition of the British Medical service is, that we should have at our hands, for use when wanted, a large body of medical officers. With this object in view, we would suggest that the Junior Medical Officers of Battalions be not dispensed with. We believe it would be good policy to retain them, while the Bearer Companies, Field Hospitals and Medical Staff be formed as intended, the whole strong enough to perform duty with a force of one hundred thousand men in the field. The

expense of retaining the Junior Regimental Medical Officer is a mere bagatelle, and should not for one moment be considered when the greater efficiency their presence would ensure is taken into account. In the formation of the Bearer Companies and Field Hospitals, Canada has been too slow. It is now within a month of two years since Director-General Neilson announced the scheme we have alluded to, and with the exception of at Halifax nothing has been done. The late General Officer commanding the militia, Major-General Hutton, conceived the insane idea of establishing Bearer Companies out of medical students at the various medical schools in Canada. Had he consulted some who could have given him good advice before taking the preliminary steps towards their formation, his scheme would have been spared the inglorious fiasco which met it. Had Director-General Neilson's programme been promptly put into action we might have been able to send one or two Bearer Companies and Field Hospitals to South Africa, where they would have been quite as welcome as are the magnificent fighting material from Canada now there and en route. No contingent from the colonies has done more notable and valuable work than the Bearer Companies and Field Hospitals from Australia.

THE WAR IN SOUTH AFRICA.

The following extract from the *British Medical Journal* of 24th February, written by Clinton T. Dent, of the Consulting Staff of Surgeons, will be read with much interest:

PENETRATING WOUNDS OF THE HEAD.

Bullet wounds actually penetrating the skull and some portion of its contents are numerous enough, and constitute at first sight the most remarkable cases met with in the military hospitals. First, with regard to the effects on the skull itself: The range will, as is well known and as has been determined experimentally, greatly influence the amount of injury inflicted on the bone. Unfortunately reliable information can very seldom be obtained on this point. All who have read the accounts of the engagements near the Modder River

and at Colenso will recognise that the men can have had but a vague idea of the range at which they were hit. At Colenso, for instance, scarcely a Boer was seen, and there were tiers upon tiers of entrenched positions. Usually the shortness of the range is much exaggerated; 250 yards is a common estimate. There is no doubt, however, that the Highland Brigade at Magersfontein were shot down at extremely close quarters. Judging by the results of the experiments made with modern small-bore rifles in England and Germany, the bulk of the head injuries seen in hospital have been inflicted at medium ranges, say 400 to 800 yards. This is really what we should expect, for at close quarters the amount of damage caused by a penetrating wound of the head is so extensive as to be probably fatal.

The more obliquely the bullet enters the skull, the greater will be the amount of damage to the inner tables. If the apertures of exit and entrance are both at a right angle to the plane of the skull, both wounds may seem to be cleanly drilled through the bone, and are scarcely to be distinguished by external inspection. But in all cases the inner table will be more or less broken up at the aperture of entrance; and if the skull is trephined there will be no doubt whatever as to the direction of the wound. Even in a long wound fragments of bone may be found lying along the greater part of the track. In not a few instances where trephining has been done at the front a second operation has been found necessary at the base, and much loose bone removed.

At very short ranges the skull may be burst open to a greater or less extent in the manner which has been shown experimentally to take place. Thus in Colonel Stevenson's work on *Gunshot Wounds* a skull is figured into which a small-bore bullet had been fired at a distance of few yards. I have not the work by me for reference, but believe the distance was ten yards. The skull is seen to be most extensively fractured. The specimen is in the Museum at Netley to the best of my recollection.

The observations made above relate to the calvarium, and instances may now be cited bearing out the foregoing remarks. I have to thank the surgeons for permission to give the following sketches of the cases under their charge. Frequently the patients as they are moved from field to base hospital or on to hospital ships have been under the care of several surgeons, and it is impossible to communicate with all. Moreover often—too often indeed—the patients are shifted about in the base hospitals, and it is far from easy to follow out a particular case without giving much trouble to the much over-

worked administrative staff. The following are examples of injury at close range :

Private D., wounded at Modder River on December 10th, 1899. Entrance wound $2\frac{1}{2}$ inches behind right parietal eminence in a line drawn between that eminence and occipital protuberance. Exit through frontal bone in right side close to longitudinal sinus. The bullet traversed at least 6 inches of brain tissue. The left arm was completely, and the left leg partially, paralysed. There was evidence of fracture of the base on both sides. Sanious discharge from both ears and deafness. The fissure seemed to split the skull in two in the vertical plane. A large flap connecting the two bone wounds was turned down and the skull trephined on the inner side of both the exit and entrance wounds. Many fragments of bone were removed from dura mater, and also blood clot and damaged brain matter. The scalp wound united at once, save over the anterior crown of trephine, where it was healing by granulation (on December 27th), and where there seemed to be some tendency to hernia cerebri. The deafness improved rapidly, and the discharge from the ears, at first abundant, soon ceased. On December 27th he could hear well ; no facial paralysis. The leg had recovered power to a very considerable extent, but, as usually happens, the footdrop was almost complete. The arm was still completely paralysed. His memory and mental condition generally were practically normal. Recovery seemed probable. Further notes of this case are promised. Probably the cortex was not damaged by the fragments of bone, but the motor areas of the arm and leg were damaged by the track of the bullet passing close beneath the cortex.

In another case of wound at undoubted short range the bullet entered close to the longitudinal sinus in the occipital vein, possibly even wounding it, and passing out through the frontal bone, traversing several inches of brain matter. The skull was trephined in front of the posterior wound, and it was found that a fissure connected the apertures of entrance and exit. Fragments of bone were removed and brain matter. Free hæmorrhage necessitated plugging the wound posteriorly, but it was not certain that the hæmorrhage came from the longitudinal sinus. Forty-eight hours later the bleeding recurred on the removal of the plug, and it was replaced. Thenceforward rapid recovery. The wound was received on December 15th, and a month later the power had almost entirely returned in the arm and to a great extent in the leg, but there was still marked footdrop. The mental condition was altogether satisfactory.

THE APPENDICITIS QUESTION AGAIN.

The *New York Medical Review* of December 30, 1899, says :

“To operate, or not to operate, in appendicitis” is still one of the absorbing questions of the hour. The physician proper still leans favorably to the expectant plan of treatment, while the operator urges removal of the appendix in all cases as being the only method of cure. The surgeon, however, weighs the pros and cons for operation in each case, and governs his action accordingly. Of course each patient, and every attack of appendicitis, must be considered as an entity, and no steadfast rules can be set down to govern all cases. Certain clinical facts have been demonstrated so often in the course of this affection that broad lines of action may be formulated upon them. Briefly stated these are as follows :

1. As we can never tell from the nature of a previous attack of appendicitis what will be the character of the next seizure, or when, if ever, it will occur, a patient who has had one mild attack should have this clinical observation clearly stated to him, and the decision for or against operation left with him. If a patient has had more than one attack, the probability of a recurrence is much stronger, and the surgeon may even urge an operation in the interval, the burden of responsibility, in case of refusal, being placed upon the shoulders of the patient. Under this head belong all those cases in which, after the subsidence of the acute seizure, the parts apparently return to their normal condition. Should adhesions of the appendix to neighboring structures have occurred, which in themselves cause pain and interference with the general well-being of the individual, there would exist a further indication for surgical interference.

2. If, during the course of an acute inflammation of the appendix, there is manifested a distinct tendency to a regression, we may safely wait for the subsidence of the attack, and then consider the patient as outlined above. Such regression is determined by careful observation of the triad of symptoms, which in relative importance are : (a) Pulse

rate ; (b) local pain and rigidity of the abdominal muscles ; (c) temperature elevation. If the pulse rate steadily declines and the other two symptoms become less marked, the inflammation is regressing, and operative attack can be deferred.

3. But if there is a distinct progression as indicated by an increasing rapidity of the pulse, and more marked local pain and rigidity, irrespective of temperature elevation, operation is urgently demanded.

4. Abscess cavities call for immediate careful evacuation.

5. General peritonitis demands immediate operative interference, except when the general condition of the patient forbids a formidable procedure. Such latter patients do better if treated expectantly, and often enough these desperate cases improve, and then their subsequent surgical treatment depends upon the local condition.

These general principles of action will be found to govern the vast majority of cases. But one must never forget that appendicitis does not always run a typical course, and in the atypical cases the internist and the surgeon both must rely on their past experiences to enable them to decide for or against operation.

FIRST INTERNATIONAL CONGRESS OF MEDICAL DEONTOLOGY OR MEDICAL ETHICS.

This Congress will assemble on July 23rd next in Paris. The first meeting will be held at the Palace of Congresses and Social Economy, situated within the Exhibition grounds. Subsequent meetings will be held at the Faculty of Medicine, 12 Rue de l'Ecole de Medicine, Boulevard St Germain. The Congress will continue one week. It is divided into four sections, before which will be discussed all or practically all subjects which pertain to the Congress. Great Britain is taking an active interest in this meeting. Canada has, of late years, taken but little interest in what we may term "Medical politeness," but it is hoped that Canadians, who propose to be at the main International Congress in the first week in August, will reach Paris in time to attend the one on Ethics. Their presence would enable them to learn how this subject is viewed by British and continental medi-

cal men. If the views which may be promulgated meet with their endorsement they subsequently might be presented for adoption by our various Canadian Medical Societies. Certainly the subject is one which commends itself to the older members of the profession, especially in our larger cities, where now-a-days medical ethics is rarely heard of, and but little acted upon. The managers in Paris are making every endeavor to arrange for the comfort of those attending, and the Secretary has sent out circulars recommending agencies. These undertake for very moderate prices to obtain rooms in advance, from 6 francs per day up, and to meet the member of the Congress at the station on arrival, look after the transport of the baggage to the lodgings, afford interpreters and so on. Such, for example, are the Agence Desroches, 21 Rue du Faubourg Montmartre ; La Société des Voyages Duchemin, 20 Rue de Grammont ; Voyages Pratiques, 9 Rue de Rome and the Voyages Modernes, Rue de L'Echelle, No. 1, Paris. All these different agencies are strongly recommended by the officials of the Congress.

Dr. J. G. Adami, of Montreal, is the member for Canada of what is called "The Committee of Patronage."

THE MINISTER OF MILITIA.

It must be a source of pride to all Canadian Medical men that a medical man—the Hon. Dr. Borden—who is Minister of Militia, has proved so efficient in the working of his department, in connection with the various contingents which Canada has sent to the war in South Africa. Few could have done as well, and certainly none better. The first contingent, collected as representative of our Militia from the Pacific to the Atlantic Ocean, sailed from Quebec fourteen days from the date of the issue of the first order for its formation. We can form an idea—from this promptness—how hard the Minister must have worked, and how ready for an emergency is his department. We hope to, in time, see some official recognition of this work. In the meantime, he may be assured that the country and medical profession recognize the splendid work he has done.

Dr. Mayrand, of St. Andrew's, died early in March at an advanced age. He graduated from McGill College in 1847. He was for many years the Surgeon of the 11th Batt. (Argenteuil Rangers), and never missed going to camp with it, where he often filled the position of Principal Medical Officer. He retired in 1898 with the rank of Lieut.-Colonel. Dr. Mayrand was an enthusiastic loyalist and militia officer. He was a most genial companion, and was beloved by all who knew him.

Dr. Albert Edward Senkler died at his home in St. Paul, Minnesota, on the 10th of December. He graduated at McGill University in 1863. He was a native of Brockville, Ont., where the interment took place.

The *British Medical Journal* of January 24 says: "We are informed that there is a movement on foot in Edinburgh which has for its object to procure for Dr. Osler, Professor of Medicine in Johns Hopkins University, Baltimore, a call to the chair of the Practice of Physic in the University of Edinburgh rendered vacant by the death of Sir Grainger Stewart."

Her Majesty the Queen has conferred the honor of Knighthood upon Dr. Thomas Lauder Brunton, F. R. S.

PERSONALS.

Dr. William Osler (M.D., McGill, 1872) has been elected an Honorary Member of the Royal Academy of Medicine of Ireland.

Dr. F. R. Wainwright (M.D., McGill, 1898), and lately one of the Resident Medical Staff of the Montreal General Hospital, has left Charlotte, North Carolina, and gone to England, with a view of entering on practice there.

Dr. Norry Worthington, of Sherbrooke, has gone to South Africa as Surgeon of C Battery, Royal Canadian Artillery.

Dr. Keenan, M.D., McGill, 1898, and lately one of the House Staff of the Royal Victoria Hospital, has been appointed Surgeon of the Strathcona Horse, and sailed with it for South Africa on the 17th March.

Dr. Sutherland (M.D., Bishop's, 1899), late House Surgeon Western Hospital, has left for Great Falls, Montana, to act as Assistant to Dr. Longeway (M.D., Bishop's, 1886.)

Book Reviews.

Histology and Pathology. By John B. Nichols, M.D., Demonstrator of Histology, Medical Department Columbian University, and F. P. Vale, M.D., Assistant in Pathology, Medical Department University of Georgetown, Washington, D.C. In one handsome 12mo. volume of 452 pages, with 213 illustrations. Cloth, \$1.75 *net.* Flexible red leather, \$2.25 *net.* Lea Bros. & Co., Philadelphia and New York.

This work is the newest of Messrs. Lea's excellent series of pocket text-books, and illustrates the growing tendency to break down the barrier between student and practitioner. Text-books used to be written for students alone, for practitioners were supposed to be done with books forever.

Another valuable principle recognized in this work is that pathology, for the most part, is only histology gone astray. The two are here included between one set of covers in a moderate compass of less than five hundred small and well printed pages, and all very attractive to the eye and to the hand.

No attempt is made to explain in words what can only be learned in the doing, that is to say the book is not "practical," because no book can be practical since practice is an affair of the hand. It does contain, however, in a convenient form a good statement of the observations and results acquired by hand-workers in both of these subjects, indeed everything which it is lawful for a student or practitioner to know. Nor are the higher problems in pathology left untouched, for there is interesting mention made of fever, immunity, susceptibility and other phenomena of a like obscure nature.

The authors, Dr. Nichols and Dr. Vale, set for themselves a definite task to present the essential facts of histology and pathology in a concise and systematic way. They have insisted upon arrangement and convenience more than upon originality, and laying aside disputed doctrines in pathology they have succeeded in presenting these two subjects in a concise and attractive way to those who may require to learn them for the first time, or who may afterwards desire to refresh the memory.

An illustration which illustrates nothing is of no value; if it misrepresents, it had better be omitted. Many of the illustrations fall in one or other of these classes. Some of the photographic reproductions, especially of the nervous system, are as meaningless as those in an English medical journal, and many of the drawings, such as those of the intestinal ulcerations, take up much space with no adequate benefit. The drawings and diagrams in the histology section are really illustrative and illuminating. Last of all, the book being designed for the pocket, it would be in harmony with this design if the thirty-one pages of catalogue at the end were given up to something more immediately useful than a list of Messrs. Lea's publications, excellent as all these publications are.

A. M.

Operative Surgery.—By Joseph D. Bryant, M.D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital Medical College; Visiting Surgeon to Bellevue and St. Vincent's Hospital; Consulting Surgeon to the Hospital for Ruptured and Crippled, Woman's Hospital, and Manhattan State Hospital for the Insane. Vol. I. Seven Hundred and Forty Nine Illustrations, Fifty of which are Colored. New York, D. Appleton and Company, 1899. Price \$5.00, Cloth. Sold by subscription.

This volume is a more than ordinarily excellent one. The reviewer has for years used the second edition as a constant work of reference, and has for some time been looking forward to the appearance of the present (third) edition, which the author has entirely recast so that it would conform to the Surgery of to-day. While the second edition, at the time of its publication, was unexcelled, the third, now to hand, is in every way superior to it.

The author's experience of twenty years' teaching of anatomy and surgery is presented to the reader in such an explicit style that the perusal of the various chapters is most pleasing, and in no sense wearisome. The rapid strides made by Surgery in the last few years has compelled the author to enlarge the work, thus necessitating the issuing of two volumes instead of one, as formerly. This fact proves that the various subjects have been fully covered. The subjects considered in this volume include general principles, anæsthetics, antiseptics, control of hemorrhage, treatment of operation, wounds, ligature of arteries, operations on veins, capillaries, nervous system, tendons, ligaments, fasciæ, muscles, bursæ and bones, amputations, deformities, and plastic surgery.

Everything is simplified and rendered clear; details are well explained, and technique is thoroughly elucidated, thus making the comprehension of operative surgery a comparatively easy matter. One of the special features of this work is the very thorough manner in which it has been illustrated, many of the figures being colored. This renders great service in making it possible to, with ease, mentally grasp and fix the details of the many and complicated operations. Taken altogether the work will prove invaluable as an instructor to the student and a reliable guide to the operating surgeon. The printing, paper, binding and execution of the illustrations are of the best. We predict for the work a large sale.

R. C.

Essentials of Diseases of the Skin. By Henry W. Stelwagon, M.D. W. B. Saunders, Philadelphia. J. A. Carveth & Co., Toronto.

The growing importance of skin diseases is well known, and the arrangement in this book of questions and answers is of great value to both practitioner and student; more so to the latter, as it is of great help to those going in for examination on the subject.

The illustrations are very good, and the work has been carefully prepared and fulfils the intention of its author.

J. M. J.

The International Text Book of Surgery. By American and British authors. Edited by J. Collins Warren, M.D., LL.D., and A. Pearce Gould, M.D., F.R.C.S. Publishers, W. B. Saunders, Philadelphia. J. A. Carveth & Co., Toronto, Ont.

The first volume of this splendid work, devoted chiefly to general surgery, is certainly a credit to the editors, and again demonstrates that the ever-widening field of surgery is best treated by several authors. The body of the text is in large clear type, supplemented by numerous short paragraphs in smaller type where the subject matter is not so important—an excellent system enabling the reader to review a subject more rapidly. The illustrations and colored plates are numerous and good. The treatment of the various subjects is essentially modern, and antiquated theories and methods are not rehearsed to the detriment of the more satisfactory ones of to-day. The chapter on the technic of aseptic surgery is very good, showing as it does the reaction from unnecessarily elaborate methods to a simple yet most complete method. The treatment of each malady is very fully considered and must be most helpful. It is a work equally beneficial to student and practitioner as a complete modern reference work.

G. F.

A Practical Treatise on Materia Medica and Therapeutics. By Roberts Bartholow, M.A., M.D., LL.D. Pp. 866. D. Appleton & Co., New York, 1899. Tenth edition, revised and enlarged.

Of Bartholow's work, which has been before the profession now for twenty-three years, there is little new to say. The author, as evidenced by this tenth revised edition, still writes as clearly and succinctly as ever. To one reading the volume for the first time, it is a marvel of compactness and completeness, with a welcome absence of discussion, which, valuable as it may be to the advanced pharmacologist, is irritating and confusing to a student and unsatisfactory to the general practitioner. It is essentially a practical work. Of the classification nothing need be said, it is practical; and as no classification of drugs that is practical is perfect, or being perfect is practical, it is perhaps as good as any, although Cushny's, of Michigan, based on that of Buchheim and Schmiedeberg, of Strassburg, is perhaps preferable. The section on alimentation is excellent, and brief enough to be easily carried. Its vast importance merits its position in the book. An extended review is impossible with the space at my disposal, but I am rather surprised to see the chloride of iron and chlorate of potassium treatment still retained for diphtheria, while the subject of antitoxines is dismissed with three pages, and the statement that 'a candid survey of the whole field constrains him to say that the practical outcome is short of the success which seemed warranted by the pretensions put forward by the original promoters.' If this refers to the whole field of diseases known to be of microbic origin, the statement is, in our present stage of experiment, unfortunately largely true, but the brilliant results in two or three diseases augur well for ultimate success in others. Coming from a recognized

authority it is apt to convey a wrong impression to the student, and I should be sorry to think that the labours of a Schaefer, Roux, Pasteur, Ehrlich, Koch, von Röch and others had reached their limit. A noticeable feature, which, while I do not think commendable, will be found very useful by the commencing practitioner, is the frequency with which prescriptions are met with all through the book. Under the heading Electricity—Public Supply—the author mentions two forms of current available from public mains—the arc and incandescent; this is probably a slip, as the terms refer to the style of lamp and not the current—what was meant probably was the alternating and direct current. The former is now used almost exclusively for both arc and incandescent lighting, motor work, galvano-cautery, etc. There is no mention of the sinusoidal current.

Altogether, the book is a valuable aid to the study of an intricate, intensely interesting, but much neglected subject. The printing and binding are in the Appletons' usually perfect style, but why do the ophthalmologists not rise up in their wrath and insist on a dull-finished paper with a uniform black type, instead of the polished reflecting surface with spider type that is at present ruining the eyesight of thousands of readers? R. W.

Annual and Analytical Cyclopaedia of Practical Medicine. By Charles E. de M. Sajous, M.D., and one hundred associate editors, assisted by corresponding editors, collaborators and correspondents. Illustrated with chromolithographs and maps. Volume IV. The F. A. Davis Co., Publishers, Philadelphia, New York, Chicago, 1899.

This *Annual*, we may again inform our readers, is arranged on a plan quite different from anything heretofore issued. It will be complete only in six volumes, two of which are coming out annually. All the matter is arranged alphabetically, so that it is a work to consult on any specific point rather than for the reading of the diseases of any particular class or system. Thus, diseases of the nervous system will be found scattered all through the six volumes, and covering a period of three years before the subject will be dealt with in full. When complete it will be a valuable work of reference, as the articles are very exhaustive and well written. Among the hundred sub-editors are the names of the best writers in Europe and America, which insures reliable and authoritative treatment of the various subjects.

The text proper is printed in large type, and references from the literature of the last 4 or 5 years is interspersed in smaller type. Numerous and well-executed illustrations, coloured and otherwise, add to the usefulness of the *Annual*.

Besides this volume a monthly journal is issued to subscribers, which keeps the reader abreast of all recent progress, and these bound, become valuable additions as references to the regular volumes. We learn with pleasure that this *Annual* is receiving warm approbation and extensive support from the profession. It will prove a valuable book of reference for writers, teachers and practitioners.

J. B. McC.

The Nervous System and its Constituent Neurons.—

Designed for the use of practitioners of Medicine and of students of Medicine and Psychology. By Lewellys F. Barker, M.B., Tor., Associate Professor of Anatomy in the Johns Hopkins University and Assistant Resident Pathologist to the Johns Hopkins Hospital. With two colored plates and six hundred and seventy-six illustrations in the text. New York, D. Appleton & Co., 1899.

This is undoubtedly one of the most valuable contributions to neurology which has appeared during the century, containing as it does all the recent advances, sifted and comprehensively arranged, in one neat volume, covering some eleven hundred pages. Readers of the New York Medical Journal will be familiar with some of the contents of this work, notably the introductory chapters. These articles appeared at intervals during two years from 1897. The bulk of the book, however, is new material. "In the first part of the volume the newer conceptions of the histology of the central and peripheral nervous organs are reviewed. In the succeeding chapters the attempt has been made to apply the neuron conception—that is the cell doctrine—as consistently as possible in the explanation and description of the complex architectonics of the nervous system."

The subject matter is included in six sections. The first five cover some three hundred pages, and include the history of the development of the neuron conception, giving the work of His, Golgi Farel, Ramon J. Cajal and others; the vital staining of nerve elements, etc.

The external and internal forms of neurons and their histogenetic relation and the neurons as the unit in physiological and pathological processes are discussed in the second to fourth sections. The bulk of the book, some 800 pages, is devoted to a consideration of the grouping and chaining together of neurons in a complex nervous system like that of man and mammals. In this section there are five subsections: first, neurons connecting the sense organs of the body with the central nervous system; the neurons within the central nervous system connecting the end station of the axones of the peripheral centripetal neurons with other portions of the central nervous system and neurons which in turn connect the end station of the latter with still higher portions of the central system; neurons connecting the central nervous system with the voluntary muscles of the body; neurons within the central nervous system which enter into conductive relation with the lower motor neurons and throw the latter under the influence of other centres, Projection commissural and association neurons of the telencephalon. One can gain an idea of the scope of the work from the above headings.

In these chapters an immense amount of work by numerous investigators is represented which the author has introduced with his own, and arranged and classified it so that an intelligent conception can be gained of the complicated distribution of the nerve fibres throughout the body. To better understand the descriptions,

the work is profusely illustrated by original drawings and selections from various sources.

Great credit is due both author and publishers for the excellence represented in the printing, illustrations and scientific presentation of an interesting but abstruse department of medical research. The book must have a great influence in promoting a more widespread interest and giving information otherwise difficult to obtain in regard to the latest developments of neurology.

J. B. McC.

Manual of the Practice of Medicine—Prepared especially for students, by A. A. Stevens, A.M., M.D., professor of Pathology in the Woman's Medical College of Pennsylvania. Instructor in Physical Diagnosis in the University of Pennsylvania. Fifth Edition, revised and enlarged. Illustrated. Price \$2.00. W. B. Saunders, 925 Walnut St., publisher. Canadian agents, J. A. Carveth & Co., Toronto, Canada.

In the multiplicity of the calls made on the medical student of the present day, ponderous Text-Books cannot occupy the place they did a decade ago. In Medicine as well as in Surgery there is much that can be boiled down, the theoretical, largely giving way to the practical. Nowhere can this be better learned than in the out-patient department of a hospital, where the practical part of medicine is ever in evidence. The author of this little manual is an out-patient physician to the Episcopal Hospital. He is, therefore, in our opinion well qualified to write a concise and practical manual. The proof of his qualification is the little volume which we most heartily commend to medical students.

F. W. C.

Braithwaite's Retrospect of Medicine. A half yearly journal, containing a retrospective view of every discovery and practical improvements of the medical sciences. Volume 120, July-December, 1899, issued January, 1900. London, Simpkin, Marshall, Hamilton, Kent & Co., Limited.

We have to thank the publishers for a copy of this journal, which courtesy we quite appreciate. When we began our professional career nearly forty years ago, *Braithwaite's Retrospect* was a standard publication, to be seen on the study table of all who desired to be *au courant* in medical matters. It is the same to-day, and fills a position not occupied by any other.

F. W. C.

Christian Science. An exposition of Mrs. Eddy's wonderful discovery, including its legal aspect, a plea for sick children and other helpless sick. By William A. Purrington, Lecturer in the University and Bellevue Hospital Medical College. New York: E. B. Treat, 241-243 West 23rd Street, 1900. Price \$1.00.

Of all modern fads, none has, perhaps, attracted more attention, or gained greater headway, up to a very recent period, than that known as "Christian Science." The utter absurdity of many of

their claims has drawn attention to the general system, which has been flooded with light. The result must be a natural death within a very short time. In this beneficial work the volume before us will play an important part, for it is a thorough *exposé* of Mrs. Eddy's claims. That this expose is necessary is clearly proven by Mr. Purrington's book, which we commend to all those desirous of posting themselves on this matter.

F. W. C.

A Text-Book of Diseases of Women.—By Charles B. Penrose, M.D., Ph.D., Professor of Gynecology in the University of Pennsylvania; Surgeon to the Gynceean Hospital, Philadelphia. Illustrated. Third edition revised. Philadelphia: W. B. Saunders, 925 Walnut street, 1900. Price \$3.75.

In the introduction the author says: "I have written this book for the medical student. I have attempted to present the best teaching of modern gynecology untrammelled by antiquated theories or methods of treatment. I have in most instances recommended but one plan of treatment for each disease, hoping in this way to avoid confusing the student or the physician who consults the book for practical guidance. I have, as a rule, omitted all facts of anatomy, physiology and pathology which may be found in the general text-books upon these subjects. Such facts have been mentioned in detail only when it seemed important for the elucidation of the subject, or when there were certain points in the pathology that were peculiar to the diseases under consideration." A careful perusal of the work, which embraces 531 pages, shows that the author has succeeded admirably in his endeavor. It possesses three qualities: completeness, conciseness and clearness. In the forty-three chapters everything has been thought of; nothing has been left out. There is a whole chapter for instance on cancer of the cervix, another on gonorrhœa in women, and another on the menopause; the last chapter treats exclusively with "the effect of the removal of the uterine appendages." Gynecology is making such rapid strides that any book which is more than two or three years old is out of date unless it has been revised. Dr. Penrose realizes this, and has thoroughly revised it since it first appeared some three years ago. This is especially important on account of the changes in treatment, which is constantly improving; those who consult this work will find that the advice given is in accordance with the opinions held by the leading gynecologists of the day. It is hardly within the province of a brief notice of the book to refer at length to any of the opinions expressed by the author. But this much we may say: that we wish every practitioner would read the chapters on lacerations of the cervix and cancer of the cervix, and on hemorrhage at the menopause. We feel sure that by so doing they might contribute very considerably towards stamping out cancer of the cervix altogether. The chapters on the early operation for tubal pregnancy and ovarian cysts are also very convincing as well as important. Many other important points might be noticed, but want of space prevents us particularizing further. The book should be in the hands of every student and practitioner.

A. L. S.

PUBLISHERS DEPARTMENT.

LITERARY NOTES.

The Living Age announces a four-part story, called "Misunderstandings," translated from the French of Madame Blanc, to begin in the number for March 3. The "misunderstandings" referred to arise from the free and unconventional conduct of an American girl in Paris, and the story is, in effect, a new "Daisy Miller" from the Parisian point of view.

Sir Walter Besant comes to the defense of Mr. Kipling from the furious assault lately made upon him by Robert Buchanan, in an article entitled "Is it the Voice of the Hooligan?" which *The Living Age* for Feb. 17 reprints from the Contemporary Review.

Mr. J. Cuthbert Hadden's article on "The Tinkering of Hymns" in *The Living Age* for Feb. 24 will strike a responsive chord in the hearts of all who object to the mutilation of the classics of hymnology.

An article on The Intellectual Future of Japan, in *The Living Age* for March 3, derives interest from the fact that it is the view of a native Japanese, reprinted from a Japanese magazine.

The leading article in *The Living Age* for Feb. 24 is a thoughtful and discriminating review of Socialism in the United States from the Nineteenth Century.