

Technical and Bibliographic Notes / Notes techniques et bibliographiques

Canadiana.org has attempted to obtain the best copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

Canadiana.org a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

VOL. XXIV.] TORONTO, FEB., 1892. [No. 6.

Original Communications.

CONCERNING LITHOTOMY.*

BY F. LE. M. GRASETT, M.B., C.M., EDIN. UNIVERSITY,
F.R.C.S.E., ETC.

Professor of Principles and Practice of Surgery, Trinity
Medical College, Toronto.

My mind is in some doubt, whether the time of this society could not be better employed by some one else and on some other subject, especially as I know of late how much has been written upon it, and I feel that I can only possibly provoke discussion, not offer anything that is new. My object is rather to give some of the results of operations done here and see how far they tend to make us decide in choosing any method for dealing with vesical calculus.

We are all aware that for a long period, the preference has been most markedly given to the lateral perineal operation, with little or no modifications, as firmly established by Cheselden. At times there has not been wanting strong advocates of the median medico-lateral, and even that by the rectum, with periods, too, in which the supra pubic has loomed up very vigorously, only to drop out of sight again. Lately this latter has again come into fashion so frequently that it seems more probable than at any previous time that it may supersede any and all the perineal methods. It may be that this is in a measure due to the strong fascination that abdominal incision has for reaching any abdominal organ without or within the peritoneal cavity, and that the bladder is not to be allowed to be an exception, yet I think its resurrection lies on a broader and better basis than that due mainly to a more accurate conception of its anatomical position. Bear with me, then, for a

*Read before the Ont. Medical Association, June, 1891.

few minutes while I shortly discuss this question, "Does the supra pubic operation afford an easier, safer, and more generally satisfactory road to the bladder for the extraction of calculus than the lateral perineal operation." Dr. Garson, in a paper in 1878, in the *Edinburgh Medical Journal*, demonstrated fully that in a frozen and then hardened vertical section of the pelvis, the bladder being previously distended with cold water and the rectum also by a rubber bag filled with cold water (if you measure accurately) you find the bladder projected above the pubes and brought within easy reach, and the anterior fold of the peritoneum well above the risk of injury by anterior incision. This paper, I think, did not get the real credit of showing that by rectal dilatation the bladder becomes so accessible and therefore suitable for supra pubic operation, mainly because the experiments he made were to show the displacements the pelvic organs undergo when the hand is introduced into the rectum, as first done by Senior of Heidelberg, and from which as a means of exploration great things were hoped for, but shortly after 1880, Peterson, of Kiel, suggested the practical use and gave the great impulse to the doing of the supra pubic lithotomy.

If then the anatomical difficulties are so small, making it such an easy task to reach the bladder that much manipulation is unnecessary, that no vessel of importance lies in our path, so that hæmorrhage is usually slight, that shock is less than in other methods, we must set over against this favorable showing the risk of opening the peritoneum and septic absorption in a wound infected by the putrid urine escaping into it, and if the surgeon, anxious to avoid the peritoneum burrows down into the loose cellular tissues behind the symphysis, the risk is bound to be increased.

The points in its favor seem strong, and perhaps they will be found to be so decided that the supra pubic may become the operation for all classes. Yet, so far as I can learn and as far as I see in this city, it is not so yet. Most of the surgeons here with English tenacity cling to the perineal and chiefly lateral, and I have been at pains to find out their results. It is not possible to give them in a tabulated form with absolute accuracy, nor do I know where to put my hand on "recent" statistics of the two forms of operation, but certainly many surgeons have had most satisfactory results

with the lateral, and I find in the last four years at the Toronto General Hospital very many more cases are operated on by the lateral than supra pubic, and the results are most encouraging, only one death, and that in a perineal medium lithotomy in a broken-down man nearly 76 years of age, and in whom the operation was done as much to secure drainage as to remove the stone. I have asked a number as to their results in private practice, and it seems to me that most surgeons in Toronto adhere to the perineal method.

I know the dangers of the lateral are usually not made light of, perhaps over estimated. I have seen a good many and I cannot recall a single case of wound of the rectum; nor a fatal case of hæmorrhage or shock. I have removed a hard calculus of large size; multiplied cases, and they all did well, and yet I feel that the trend of opinion is so strongly in favor of the supra-pubic that a surgeon looked pityingly at me when I told him I still used it, and said, Come and I will show you the spot. It is especially pointed out that in children the supra-pubic is always easy and safe, because in them the anatomical conditions are naturally what we by artificial means make them in the adult, the bladder in children being almost an abdominal organ and the peritoneum well out of the way. I think this has much truth in it, and is probably the more advisable operation, notwithstanding the fact that perineal lithotomy in boys under ten is a very successful operation, still it does away with two objections: first, that no injury can be done to the ejaculatory ducts leading to impotency, and again that it is not very difficult to open the recto-vesical pouch and fancy one is in the bladder, with, of course, disastrous consequences.

In the aged, with an enlarged prostate, perhaps, and dilated prostatic venous plexus, the hæmorrhage is often free, and does sometimes cause death from shock, due to the sudden abstraction of blood in a person advanced in life. Such case would be favorable for the supra-pubic, if it were not unusual to find the bladder contracted as the result of long standing irritation and disease, possibly even adherent, offering a mechanical obstacle to dilatation by fluid injected into it, and to its projection forward by distension of the rectum.

I believe, with very large stones, no one will doubt that it affords the best means, but the increase of

surgical knowledge and skill in the present day is so great and so widely diffused that it is not often that stones go unrecognized in the bladder and attain such huge proportions as to debar their removal by the perineal incision.

As a means of drainage of the bladder it seems so strongly advocated by Hunter McGuire, of Richmond, and others, that the supra-pubic method of drainage will supersede the perineal.

STATISTICS.

T. 13—All lateral, all recovered.

W. 12—All lateral, all recovered.

F. 8—All lateral, seven recovered.

M. 6—Supra pubic, one death, many lateral all cured.

THE CARDIAC PHENOMENA OF RHEUMATISM.*

BY ALEXANDER M'PHEDRAN, M.B.,

Associate Prof. of Clinical Medicine, Univ. of Toronto.

(Continued from January number.)

In endocarditis the inflammatory effusion takes place into the fibrous tissue of the membrane, the surface changes follow later. As compared with the serous membranes, as the pericardium and pleura, the inflammatory process is very circumscribed; this is owing to its slight vascularity. The reason hitherto assigned by most authors for the frequency with which the mitral valve is affected, and the rarity of the aortic, has been the greater strain to which the mitral is subjected. Later authors* give another cause which seems, on the whole, to be more potent, viz.: the fact that the central parts of the mitral segments have some vascular supply while the aortic segments are quite non-vascular. The onset of endocarditis may be accompanied by pyrexia and an appearance of illness and distress in the child's face, even while at play; or the heart's action may be tumultuous with dyspnoea, restlessness and anxiety from imperfect circulation. But such symptoms occur only in the severer cases. Valve disease gives no physical sign of its existence until it results in some deformity of the valve which either impedes or disturbs the current of blood in its passage

* The address on Medicine, Ontario Medical Association, Toronto, June, 1891.

* Ziegler's Pathology.

through the orifice, to whose margin its segments are attached, or impairs the functions of the valves, so as permit a reflux of blood through the orifice, which they guard.

Sibson* says we are warranted in assuming that in a considerable number of cases the active stage of endocarditis is passing away at the time of the appearance of a murmur. As a general principle, it may be stated that the milder the endocardial inflammation the longer will a murmur be in appearing, and *vice versa*; in many mild cases certainly no murmur ever appears. It is probable that endocarditis may abate with complete removal of the exudative products, leaving no trace of the inflammation. Usually, however, some thickening persists, and, if slight attacks recur, in time the segments become adherent, causing stenosis of the mitral orifice, or, less frequently, probably, incompetence of the valves and regurgitation, on account of the deformity of the valves from shrinkage of the new tissue. I say less frequently, because regurgitation results usually, if not always, from the more acute attacks, while mitral obstruction probably never does.

The first sign of mitral stenosis in about half the cases is a seeming reduplication of the second sound heard at the apex only. The first of these sounds is produced by the blood passing over the tenal mitral valve, which only slightly narrows the orifice as yet; a sound is thus produced which is almost synchronous with the aortic sound and both are heard at the apex only. As the case progresses the presystolic, or rather, at first, the diastolic character of the sound becomes apparent*.

If the lesion lead to incompetence of the mitral valve, the first indication will be a prolongation of the first sound of the heart as heard at the apex. Mitral obstructive murmurs probably always persist, but regurgitant murmurs may disappear. The former are organic, the latter may be functional, being due to adynamia of the cardiac muscle. This adynamia results in imperfect contraction of the mitral orifice during systole and consequent incompetence of the mitral valve. Such murmurs disappear as soon as the heart recovers its tone, but during their existence they are indistinguishable from those of organic origin;

in both conditions the heart is likely to be somewhat enlarged. While it is possible for murmurs in rheumatism to be functional, it is best, from a therapeutic point of view, to consider them all organic, and treat the case accordingly. It is worthy of remark that in rheumatism, murmurs occur earlier than do the functional murmurs of any of the other depressing diseases, thus indicating a different origin.

Pericarditis.—For want of space, only a brief reference can be made to this and to myocarditis. There is no cardiac affection, probably, more often overlooked, or whose symptoms are more often misinterpreted than pericarditis. Nothing has mortified one more than to discover in the mortuary a severe pericarditis that was not suspected in the ward. The symptoms are so liable to be masked by those of the primary disease that the possibility of its occurrence should be constantly remembered in those diseases which it often complicates, especially in rheumatism and Bright's disease.

Unlike endocarditis, it is more likely to occur in the first than in subsequent attacks of rheumatism. It is much more apt to occur in severe than in mild cases, and is usually met with from 15 to 25 years of age. It is rare in the young, yet one of the worst cases I have seen was in a child, at six years, in the practice of my friend, Dr. Byron Field, of this city, last year. The child had a mild attack of rheumatism, the symptoms of which disappeared in a few days, when attendance ceased. Two weeks after the commencement of the rheumatism he was exceedingly pale-faced, exhausted, anxious, pulse very weak and rapid, respirations hurried and labored, so that he required to be propped up on pillows. On examination, the area of præcordial dulness was found slightly enlarged with a somewhat diffused impulse, the sounds were weak and indistinct; the temperature was slightly elevated. Over the præcordial area ill-defined friction could be detected. As was expected, autopsy showed the existence of a very severe pericarditis with abundant fibrinous exudate, and accompanied by a myocarditis affecting the whole cardiac muscle. This case illustrates the condition met with in pericarditis complicated by myocarditis at all ages. Severe, even fatal, cases of pericarditis may show very slight symptoms. Sibson found præcordial pain present in three-fourths of his cases; so that

* *Ibid.*

* *Sansom. Lettsomian Lectures, 1883.*

such pain, however trivial, should receive careful consideration in all cases of rheumatism.

Most authors agree in describing delirium of various forms as frequently present, even in the absence of febrile movement. When endocarditis complicates the case the delirium is liable to take on a suicidal tendency; and of the character of *delirium tremens*, when there is some fever with prostration.

It was most marked in "dry pericarditis, disappearing with effusion." Such pain was very marked in a case recently under my care, in which there was, as well, severe and obstinate pain, produced by the act of swallowing, probably due to pressure on the pericardium posteriorly. The disease is usually latent, however, and will escape notice unless sought for with the utmost care. In all cases there is a tendency to rapidity and weakness of the pulse with dicrotism, probably from a certain degree of implication of the myocardium.

Myocarditis probably seldom occurs independently of inflammation of either the endo- or pericardium, especially of the latter. Maclagan, however, is very positive of the frequent occurrence of a primary inflammation of the heart muscle, and that it may be diagnosed by the weak, rapid dicrotic pulse. Its existence in any case, of course, adds materially to the gravity.

Prognosis.—With the exception of cases in which the cardiac muscle is seriously affected, the immediate prognosis is usually favorable; few die as the result of the heart disease apart from myocarditis. In young children, however, suffering from acute disease, the heart yields more readily to strain, probably on account of the immaturity of the tissues, hence they bear disease badly. But if they escape the immediate effects of the disease the heart recovers itself more readily and develops more rapidly, hence compensation is soon established and emphatic. On this account we seldom see evidences of much impediment to the circulation, as great enlargement of liver and spleen, cyanosis and extreme dropsy; these are more frequent as age advances. Goodhart attributed this partly to the anæmia with diminution in the quantity of the blood as part of the general wasting.* Cheadle gives another cause. "Children with severe heart disease, as a rule, die from

other causes before the stage of grave tricuspid leakage is reached. Instead of the engorged liver and lung, with blueness, extreme dyspnoea and general dropsy," as seen so often in adults, "there is rapid wasting, progressive anæmia, feebleness and death from asthma rather than from the direct injury to the mechanism of the circulation."* Fagge† says the aspect of a child with cardiac disease is rather that of phthisis. He is pale and thin, with dilated pupils, a delicate skin, and quick pulse. In older children and adults, the ultimate prognosis usually depends on the degree to which the lesion causes interference with the functions of the heart. In young, well-nourished persons it is often amazing what extensive valve changes may be compensated for, and for what almost indefinite duration the compensation may be maintained.

In older persons the prognosis will depend greatly on the condition of the vascular system, being rendered less favorable by any sclerotic or other unctous changes that may be present or develop. Leyden says that age does not impede the development of compensatory changes in cases of valve diseases. With advancing age the cardiac muscle gains in volume and power, and the heart is the only organ whose comparative bulk increases with age, so that perhaps the heart of older persons has even more endurance than that of younger ones.*

In recent cases, we should not forget that the evidences of disease, especially mitral incompetency, and occasionally aortic obstruction, may disappear after some weeks, or, it may be, months. Over against this, unfortunately, we have to set two unfavorable possibilities, namely, that a lesion which, just after its development, but slightly disturbs the mechanism of the circulation may increase, from the tendency of the new cicatricial tissue to contract, and secondly, that one attack of endocarditis predisposes to another, especially in the anæmic.

Then much will depend on the mode and circumstances of life. The prognosis is more favorable among the well-to-do, for, while they are exposed to the liability of over-feeding, with its tendency to cause arterio-sclerosis and atheroma,

* *Ibid.*

* *Principles and Practice of Medicine*, Vol. I. p. 983.

* *Annual of the Universal Medical Sciences*, 1890.

* Cheadle-Harveian Lectures, *Lancet*, 1889. Vol. I. p. 926.

they are spared the necessity of exposure and over exertion, which so many of the laboring class have to endure. In arriving at an opinion, all the circumstances of each individual case have to be taken into consideration.

The ultimate prognosis in the large proportion of cases is, without doubt, unfavorable, yet some go through life and attain old age with marked disease of the heart, and it is better to err on the hopeful side than take too gloomy a view of any case.

The late Austin Flint used to relate a very instructive incident from his own experience on the prognosis in heart disease. Shortly after beginning practice he was consulted by the parents of a young girl with decided mitral insufficiency. His prognosis was unfavorable. He said the danger was imminent and but little improvement could be expected. He advised them to prevent all but the quickest movements. Little heed was paid to his advice; the child was allowed unrestrained freedom with other children. Twenty years afterwards Flint saw this girl, now a mature woman, leading an active, useful life.

It is scarcely necessary to an audience such as this, to say that only exceptionally should prognostic significance be attached to cardiac murmurs, since lesions of the most trivial nature may cause murmurs of the most marked character. It is true that sometimes they afford considerable assistance in judging of the future prospects of particular cases, yet these are exceptional; ordinarily they should have no place in prognosis.

Treatment.—This includes prevention as well as management of the case after the heart disease has developed. The most effectual means to prevent the cardiac disease is, of course, to prevent the rheumatism which causes it, but we have no remedies to effect this purpose. We can but avoid the causes, preserve the best attainable health, and protect the person against such influences as cold and wet, as cause rheumatism.

If the rheumatism occur we are then driven back to preventing the heart becoming involved. To do so we should arrest the rheumatic process as soon as possible. It is claimed by many capable observers that the alkalies are our best remedies for this purpose, and that if given freely before the heart becomes affected that they will prevent that complication. More recently it is claimed that

under the salicylates the heart enjoys equal immunity. Being compatible with each other, most physicians try to obtain the good effect of both by combining them. How far either or both these remedies deserve credit for power to prevent this phase of rheumatism is uncertain, but there is no doubt that they have little or no influence over the cardiac disease once that is established. As further aids in preventing the heart affection we should promote excretion so as to relieve the system from the irritation of the waste products and thus relieve the heart also from the increased labor incident to retention of waste in the blood. The purer the blood the more easily is the circulation maintained.

Then the nutrition should be carefully maintained by the administration of light liquid nutritious food at short intervals so as to forestall the anæmia that almost always threatens. And the condition of as complete rest as possible should be maintained, so as to relieve the heart of all the strain possible, even in the mildest cases, in children particularly.

Sibson,* in his wide experience, found that while absolute quiet and rest seemed to have little influence in preventing the occurrence of the signs of heart lesions, it had great power over the permanence and increase in those lesions. He found that the signs of heart disease completely disappeared or persisted only in a slight degree in a much larger proportion of those cases who had been kept at rest and carefully tended than in those who were allowed freedom to exert themselves, even though otherwise well cared for. It therefore becomes of the utmost importance that rheumatic persons, especially the young, should be put to bed on the first symptoms, however trivial, showing themselves, and that they should be kept there until so far recovered from the rheumatism and its attendant anæmia, as to ensure the safety of the heart, and protect against a relapse of the rheumatism.

In the anæmic and debilitated attacked by rheumatism, it is doubtful if the benefit derived from the alkalies and salicylates, especially the latter, is not more than counterbalanced by their tendency to increase the anæmia, and thus the liability to heart disease. For my own part I have seen more benefit apparently result from the free administration of iron in these cases, preferably

*Ibid.

the tincture of the chloride. If salicylates are given to such patients they should be discontinued as soon as the acute symptoms are overcome, the iron being given from the beginning and continued.

In children, in whom as already pointed out, rheumatism is so seldom acute, there is rarely occasion for heroic treatment with salicylates; besides it is probable that the alkalies are more potent in them in preventing the heart affection. Then the first tendency to anæmia in rheumatic children should be constantly before our minds and no effort should be spared in counteracting it by every possible means; therefore great care must be exercised in diet, which should be nutritious and easily assimilated. At the same time care is needed to prevent over feeding and the risk of a relapse.

The securing of adequate rest is the most difficult part of the treatment of heart disease in children, especially in boys, particularly as the rheumatism is usually so mild. When first seen, the heart is often affected. Many a boy has had his heart irretrievably damaged and his life cut short by being allowed, while subject to latent recurrent attacks of rheumatism, to indulge in the usual games that are healthful to the healthful boy

Selected Articles.

A CLINICAL LECTURE ON COMMON DISEASES OF THE RECTUM.

We are constantly having in the wards cases of severe disease of the rectum—I mean cases of piles which require operation, cases of fistula, and cases of cancer. I propose to-day to speak rather of the commoner cases of disease of the rectum, such as you will meet with among out-patients and in your own practice later on. Ordinarily the rectum performs its function without any disagreeables, and when one has a healthy evacuation of the bowels there is a feeling of relief which is somewhat remarkable. That evacuation, of course, should be perfectly painless, and in the great majority of instances it is so; but you will find, when you get into practice, that patients will complain to you in the first place that they cannot get the bowels open, and then perhaps they will say that when they have had them opened they suffer such pain that they dread every operation.

With regard to the question whether a daily action of the bowels is essential to good health, I

may say that no doubt, with the great majority of persons, a daily action is a necessity, but still you may meet with people who are a little different in that respect, and will go two, or even three or four, days without evacuation and without any discomfort. I mention that because it is well to consider the idiosyncrasy of each individual. It is of no use, where you have torpid bowels and a weak condition of the muscular fibre generally, such as you meet with for instance in elderly females and anæmic persons, to try and force them by violent purgation into the ordinary daily habits of healthy people. Of course, if you take a healthy person, you have there a standard, but you may find variations from it for which you must be prepared. As to the time at which the bowels should be opened, that of course in many cases, is a matter of simple convenience. The busy man, going off to catch a train immediately after breakfast, had better perhaps have his bowels opened at night, but a person who has a little leisure, and, moreover, is able to enjoy that matutinal pipe which, I am told, is so extremely useful in producing an alvine action, may well repair to the water closet after breakfast; but take my word for it, that patients who have anything the matter with the rectum, who suffer in any way upon the discharge of fæces, should, as a rule have their bowels opened at night; and the reason is obvious. The action of the bowels takes place more conveniently after they have undressed: that is an important point in connection with women who wear tight stays—when they are in their dressing-gowns or nightgowns they have much more power to empty the bowel than at any other time, and immediately after they have done so they can repair to bed, where they can lie in a horizontal position for eight or ten hours, so that any little inconvenience, any disarrangement of the vascular supply of the bowel passes off, and in the morning they are quite well.

If there is any difficulty about the action of the bowels patients are only too ready to fly to purgative medicine. You have only to read the advertisement columns of the newspapers to see what fortunes are made by purgative pills. The great secret of these pills is that they are extremely mild, so that it takes half-a-dozen to produce any action, and the patient will very soon get through a box of twenty or twenty-five, and then will have to buy another box. There is a sort of popular idea that anything like aloes is very apt to do harm to the lower bowel. I believe that is a pure delusion. Patients who have trouble about the rectum can use aloes without any particular disadvantage; indeed, I think it is rather a good drug to prescribe, because it has a stimulating effect upon the lower bowel.

Then, besides purgatives, which are not to be had recourse to unnecessarily, we have ordinary

laxatives, and the fashionable laxative of the present day is some form of mineral water. You find large quantities of mineral waters advertised, which are more or less artificial in their manufacture, and which can be drunk in quantities, say, of a wineglass in a tumblerful of warm water before breakfast, producing an alvine evacuation soon after breakfast. That is an example of the kind of thing people are now in the habit of taking. But there are very much older remedies; for example, there is sulphur, a teaspoonful or two of which may be conveniently taken in milk. The old-fashioned confection of senna has been superseded now pretty much by the nicer preparation of compound liquorice powder, a teaspoonful or two in a little water early in the morning or over-night producing an easy evacuation in the morning.

Then there are methods of attacking the bowel itself. By far the simplest and the best method—very little used in this country, comparatively speaking—is the ordinary enema. You will find that enemata are very seldom prescribed nowadays, but if you have cold water thrown up into the bowel with a simple Higginson's syringe, such as I hold in my hand, you will help many patients to produce an evacuation comfortably, without any distressing strain. There is no need for any complication of reservoirs or anything of that kind for the water which you throw up into the bowel. In the present days of water-closets, all that the patient has to do is to empty out the pan of the water-closet, fill it up with cold water, and, having previously filled the syringe, then introduce the pipe into the bowel, and inject a pint or a pint and a half of water. After waiting a few minutes, the strain upon the sphincter becomes a little strong; the evacuation takes place, and the fæces are brought away with the enema. It is curious how little these enemata are used in this country as compared with France. In England there is a sort of modesty about these things, and you will find that people object to an enema when its use is very advisable. Many women in particular, who have a somewhat feeble lower bowel, derive great advantage from throwing up cold water into the bowel at the time of the action.

Then there is another thing that has come into fashion of late—the injection of small quantities of glycerine, which no doubt in many cases is extremely useful. The chemists sell a small syringe for the purpose, holding from one to two drachms, and patients have got into the habit of throwing up a small quantity of glycerine just within the sphincter, and in a few minutes the action is produced. In many cases—I will not say in all—it is really a very efficient remedy.

Another thing that I may mention I have known for a great many years, but I find very few people comparatively know of it. The diffi-

culty which many persons experience in getting rid of a mass of fæces which has been lodged in the upper part of the rectum and become a little inspissated and hard, can be got over entirely by pressure with the finger just beyond the tip of the coccyx. There is plenty of room between the tip of the coccyx and the anal orifice for the finger to be pressed against the rectum, and you will find that the hard motion which has lodged in the rectum is pushed out through the sphincter, and being once through it is promptly passed, and the softer matter follows easily enough.

You must be prepared sometimes to find that a woman who is having apparently a healthy evacuation daily yet retains in the upper part of the rectum large masses of fæces in the shape of balls. It is very remarkable how fæces get retained in this way. I cannot tell you why it should happen with one patient more than another, but I have seen it over and over again; the fæces rub against one another, and become formed into distinct balls, which remain there, and which the patient cannot get rid of by any voluntary effort. I am quite sure this is much more common than is generally supposed. I have met with it many times, and always in women, not necessarily elderly women who have borne families, but generally elderly women; they complain that they are never comfortable, that they never get that feeling of relief they should have, but are always straining and bearing down almost as if in labor, and at last matters come almost to a stoppage. It then becomes a question of clearing out these hard balls of fæces with a lithotomy scoop or the handle of a table spoon, which will do on an emergency. In that manner you can evacuate the bowel in a way that the patient cannot do for herself. It is quite worth while, then, when a woman complains of uneasiness about the rectum, to put the finger up so as to make yourself thoroughly sure that the upper part is not blocked with these balls.

Suppose, now, that the patient complains that every time he has an evacuation he feels pain, and that the pain lasts for an hour or two afterwards, and is really so bad that he dreads every evacuation. You may at once say in such a case that the patient is suffering from fissure, though the patient very likely thinks he has piles. Now a fissure, in the great majority of cases, is, I believe, a tear; the patient has happened to have a very hard motion, which has been forced through the sphincter, and has distended the part, and torn the mucous membrane. That is, no doubt, the explanation of the formation of a fissure in most cases. In addition to that, there may be, if it is a long-standing case, a little ulcer above the sphincter which communicates with the fissure. But, presuming that it is a comparatively recent case, and simply a fissure, if you look at the anus you will see a little crack running up through the

mucous membrane; and if you put in your finger, which should of course be greased, the sphincter spasmodically contracts, but if you gently insinuate it with a twisting movement you will at last pass through, giving the patient considerable pain, but you will ascertain that you have there the crack running up the anus through the mucous membrane only, but going down to the fibres of the sphincter. Of course there is nothing so good as a finger for ascertaining this, but if you have any doubt you can use a small bivalve speculum, which is introduced closed, and is then opened so as to bring the aperture opposite where you think the crack is, and you can then see the fissure running up through the anus. There is also another variety of speculum—the small Fergusson's speculum—with an opening at the end, or with the opening running the whole length.

These cases of fissure are very often of long standing, and in that case you very commonly find that there is a little mass of granulation protruding into the fissure, sometimes wrongly called a polypus. You should always look for that, because it is important to remove it. The reason why a fissure is so excruciatingly painful is that it runs down to the fibres of the sphincter, and when the faeces pass they irritate the fissure and the sphincter, and there is a spasmodic contraction of the muscle, which is exceedingly painful, so that the patient tells you he is obliged to lie down for a couple of hours after an evacuation, and he feels sore for some time. These cases are very readily cured. If it is a recent fissure, and if the patient is in delicate health, say a pregnant woman, you may not care to do more than apply something locally to the fissure, and if it is simply a superficial one, I know nothing better than some form of belladonna, either belladonna ointment, or, what is rather nicer, ointment made up by mixing a grain of sulphate of atropine and half an ounce of lard. That makes a good ointment, not too strong for use, and it relieves the patient very much, and seems to help the part to heal up. But it must be a very slight case for that to cure it. The same thing may be said with regard to nitrate of silver. It will cure fissure if you are very careful. If you have a sharp pointed stick, and then through a speculum draw it down just into the fissure, so as to go quite to the bottom, it may be possible to cure it. But I strongly advise, in most cases of fissure, that you should do something a little more active. The best thing is to over-dilate the sphincter. If you over-dilate the sphincter, you no doubt tear a few superficial fibres, and thereby paralyse the muscle a little, and the consequence is you cure the fissure. The simplest way is to put two fingers, or better, two thumbs, into the anus, and grasping the buttock, then draw them apart. As it is painful, it is well worth while giving an anæsthetic; but it is not a

long operation, and it does not lay the patient up. If he is kept quiet for a couple of hours he is immediately relieved of pain, and the first time there is an evacuation there is no pain at all. Another way is to notch the sphincter with a bistoury. That is a thing which in the early part of the century was made a very serious operation of by cutting through the whole sphincter, which is quite unnecessary. It is quite sufficient simply to notch and divide the superficial fibres of the sphincter. You pass a blunt pointed bistoury with the finger into the rectum, turn the edge of the bistoury to the fissure, and withdraw the knife and finger together. Some prefer that operation, but I do not think it makes much difference which you do. It is well, however, sometimes to be able to assure a nervous patient that there need be no cutting operation.

With regard to the little ulcer which occasionally exists within the bowel in connection with a fissure, there is no doubt that in that case division is best, because the bistoury is carried through the ulcer, and it cures both it and the fissure. But if there is an ulcer the case takes longer to heal; you have to lay the patient up a week or ten days because the cut has gone through the ulcer.

Another thing of which patients complain is pruritus ani. The patient will tell you that he is worried to death by itching about the anus; that it comes on as a rule at night when he gets warm in bed; that he loses his rest, and that his health is thereby considerably interfered with. There are various causes for pruritus ani. It is well to remember that there may be some local cause which can be got rid of at once. One of the common causes of pruritus ani in children, and sometimes in adults, is the presence of ascarides in the rectum. Within the last few years the views about ascarides have a great deal altered. It used to be thought that they lodged entirely in the rectum, and that you could cure the patient by copious enemata, usually of salt and water. But it has been shown within the last few years that that is not a fact, and that these ascarides have their habitat mainly in the cæcum, and are to be found more or less throughout the whole length of the large intestine. You must bear in mind, then, that it is not sufficient simply to attack the rectum with enemata, but you must give purgative medicine also, which will act upon the cæcum and clear away the worms themselves and the mucus in which they are lodged. You may often see them coming away in large balls as the result of purgative medicine, and until they are thoroughly cleared out you cannot hope to cure the patient.

Another thing to bear in mind is that you may occasionally have pediculi. The pediculus pubis, the ordinary crab of the pubes, if it exists, may find its way readily round to the anus. It is

therefore well worth while to make an inspection both of the pubic hairs and of the anus, to see whether or not you can detect the pediculus, which, as may well be seen with a magnifying glass, bears a close resemblance to an ordinary crab. If once made out, this is readily cured. You can get rid of crabs by two or three applications of some mercurial lotion, such as the *lotio hydrargyri flava*, carefully soaked into the hairs, which will kill the pediculi, and hot water and soap will then put matters right.

But, unfortunately, as we know to our cost, pruritus ani does not always depend upon local causes. You find that a patient is perfectly clean and that no worms exist in the rectum, and yet he suffers almost agonies from pruritus. If you consult the authorities you will find that every remedy that has ever been recommended has been tried with more or less success, which shows how little successful the remedies really are. For myself I rather believe in lotions than in ointments. On the other hand I allow that sometimes ointments answer extremely well; but I think you may get most relief, in the majority of cases, in the first place by attending to the general health, keeping the bowels regular, and so on, and then applying locally some sedative. Cocaine is not a bad thing to apply. A five per cent solution of cocaine painted over the anus will often give great relief. Before cocaine came in we used hydrocyanic acid, and that was extremely useful in the form of a lotion of dilute hydrocyanic acid and lead. Opium and belladonna, atropine (the essential part of belladonna) and all the various sedatives have been tried from time to time with more or less success, and, I am sorry to say, with more or less failure. It is a curious thing, but you will find that patients sometimes go on for a long time suffering with this annoying and troublesome complaint, which no remedy seems to touch, and then they get well; but it does not always appear what it is that has cured them.

Then we meet, as we do everywhere, occasionally, with syphilitic affections of the anus. Children are brought to the hospital from time to time with distinct mucous tubercles about the anus. It is a little difficult sometimes to explain this occurrence, but I believe the explanation often is the ridiculous habit that mothers and nurses have of kissing the children all over. They are not particular what part of the child they kiss; and sometimes the unfortunate child's anus is inoculated in that way from the lips of the nurse. But you will find cases that you cannot account for in that way. There is no doubt that from time to time we have mucous tubercles simply from vaginal discharges creeping round: I mean that a woman has mucous tubercles of the vagina, or labia, and the discharge run back to the anus and produces mucous tubercles there. Occasionally you may also find

that persons get them from their bed-fellows. I do not mean by any outrageous bestiality, but that some contact from their bed fellows has accidentally inoculated that part. Mucous tubercles are readily recognised as flat moist patches, and the only thing I will say about them is that you must be careful in treating them to keep the adjacent parts from rubbing one against the other. If you have to treat mucous tubercles about the anus apply some mercurial dressing which shall separate the two sides of the buttocks and prevent their rubbing together. I have always found that the best plan is to take a piece of linen, spread it with white precipitate ointment, and tell the woman to fold it so that the ointment shall be outside, and then to draw it thoroughly between the buttocks, so that the mercurial ointment shall come in contact with the anus and thus become rubbed into the system. You will remember that mucous tubercles are but a symptom of secondary syphilis, and if you find them about the anus you may be sure that the individual has syphilis in his system, and their treatment will be only part of the general treatment of syphilis, into which I need not now enter.

Then we find occasionally about the anus what are termed rhagades. There is hypertrophy of the skin of the anus with ulceration in the cracks between the folds, which is undoubtedly syphilitic, and should be treated very much like mucous tubercles. But you will find occasionally that there are considerable outgrowths of moist skin about the anus which are commonly called "tags." They are not really a disease, but are only a symptom, and wherever you see them you may be sure that the woman—for they usually occur in women—has syphilitic disease of the rectum. You should at once introduce the finger, and you will probably find ulceration of the rectum of a tertiary syphilitic character, with very likely more or less stricture. We do not happen to have had lately in my wards any case of the kind, but you will see from time to time women who have had these tertiary ulcerations of the rectum, which lead later on to very severe stricture, and occasionally require operative interference.

A mother may come to you saying that her child's body comes down—that is the expression generally used among the poorer classes—and she at once assumes that it is a case of prolapsus. Now, be on your guard about that, because cases of the "body coming down" are not all cases of prolapsus. Of course many are, but you should observe the case for yourself, and take the trouble to put your finger into the bowel. In many cases you will find that there is a little pedunculated growth hanging there, which, when the child strains, comes through the sphincter or presents at the anus, and which is nothing more nor less than a polypus. These small rectal polypi are not un-

common in children, and the remarkable thing about them is that they generally cause some hæmorrhage. Every time the bowel is open there is some little blood noticed in the stools, and yet if you come to treat them by taking hold of them with your nail and tearing through the pedicle there is no bleeding, and the case gets well directly. If the pedicle is at all thick it is wiser perhaps to put a ligature upon it, but if it is a simple polypus in a child you may, without scruple, tear through the pedicle with your nail and bring the little vascular body away, and no hæmorrhage ensues. So much for polypi, which you occasionally find in young adults in whom they become more or less indurated, and, though they are not nearly so vascular, they are thought to be piles. The patient says he has piles, and that every time he goes to the closet the pile comes down, but when you see it, it is simply a pedunculated mass, which should be treated by putting a ligature round the pedicle and cutting it off.

True prolapse occurs both in children and in adults. In children it occurs most frequently, I believe, as the result of debility and, also, no doubt, as the result of the bad habit which is so common, of allowing children to sit and strain their bowels after they have already evacuated, and at last they strain down the mucous membrane. These are really cases of prolapse. There may be a more severe condition, which we call procidentia, where the whole bowel comes down. That is more serious, and I will speak of it presently.

Prolapse may be a symptom of other disease. It is not very uncommon in cases of stone in the bladder to find a child straining to make water and bringing down the rectum at the same time. It is therefore well to bear in mind that you may have another disease behind and to enquire whether the child has serious trouble in making water. But ordinary cases of prolapsus are cases simply of debility, the child is of weak habit altogether, and the bowel has got into the way of coming down on very slight occasions. The great thing is to break through the habit, and if you can make the mother take a little trouble you can break through it readily enough. With a circular opening like the anus very little will bring down the mucous membrane through it, but if you can get the mother to hold the child when it is going to have an evacuation and to put the finger down the verge of the anus and draw on one side, and thus convert the circular opening into an elongated slit, then the mucous membrane is considerably puzzled to come down, and practically it does not prolapse. What I always promise mothers is that if for one week they will take the trouble to do this and so prevent the bowel from coming down the case will probably be cured. In addition to that little manoeuvre it is well of course to brace up the bowel by throwing in cold water with an enema syringe, both before

and after evacuation, and to give the child a tonic, particularly an iron tonic.

If the bowel comes down and is allowed to remain down for some hours, you may find it rather a difficult job to put it back. The shortest way is to give the child chloroform, then to manipulate the bowel and to return it with the piece of lint with which you have manipulated it. If you simply push the prolapse up and take your fingers away, it comes down directly; but if you take a strip of lint and then squeeze the blood out of the bowel, you can push the lint and bowel back together, and the lint remaining in the lumen of the bowel keeps it in its place. After some hours the lint will come away spontaneously, or with the next evacuation, and then the case is relieved. In order to keep up the bowel in an obstinate case it is not a bad plan to do as Mr. Ionides did in a case that he had here lately, namely, put a strip of plaster across to hold the two buttocks together, so as to prevent the bowel coming down again.

These cases of simple prolapse are readily enough treated, even in the adult; but we occasionally get cases of procidentia, where the whole bowel comes out, and they are exceedingly difficult to cure. It is curious that women who have that kind of thing sometimes seem to have a morbid liking for it. They do not want to get cured; it is a form of hysteria, no doubt; they like to be made martyrs of—to be kept in bed, to be always suffering, and to have their friends rallying round them, converting their bedroom into a sort of reception room. I shall never forget one case I was called to see. It was that of a lady, who was a leading light amongst her religious party, and who had been confined to her bed for many months—I fancy for years—by a large prolapse of the bowel. I was asked to examine her, and I could find no reason why the bowel should not be returned. But she did not want it returned, and she resisted every effort that I made; the moment I put it back she strained and drove the bowel down again, so that I had to give it up as a bad job.

Within the last few years I have been very successful in curing some of these cases in the hospital with the actual cautery. If you have a great prolapsed bowel, of course it will never do to cut it off. If you did that, you would probably find that, just as with a prolapsed uterus, you would cut off a piece of peritoneum. But when you have a prolapse forming a large sausage-like projection from the rectum, you can apply nitric acid, which some recommend, but which I do not think quite sufficient for the purpose. I prefer to use Paquelin's cautery. The method is to draw a series of vertical lines upon the prolapse, and then, under chloroform, to put the part thoroughly back, and with the cautery to cut two or three deep grooves in the anus itself, because in these cases it is enormously dilated, and, unless you thoroughly

contract up the anus, no power will keep the bowel within. Then, of course, you lock up the bowels with opium, and keep the patient carefully in bed. As far as I have seen, we generally get a cure in such cases, though sometimes the cautery has to be applied more than once.

A patient comes to you, and says that he is very uncomfortable because he has a little swelling which is very painful. You will find a little bluish mass by the side of the anus, and as far as I have seen it is more common in men than in women. It is nothing more nor less than a thrombus in one of the inferior hæmorrhoidal veins. You find, perhaps, that the patient has been dining out once or twice of late, and his bowels have become a little constipated and the liver overloaded, and the venous circulation obstructed. Every now and then patients will go on suffering this inconvenience for a few days without taking advice, and the thing gets well; that is, it gets well by absorption of the blood clot, and by leaving a loose fold of skin at the verge of the anus. That is how those loose external piles we see so commonly are formed. But if you get the case in an early stage, by far the best thing to do is to make a little nick with a bistoury into the swelling, and to turn the clot out. It turns out very readily; you get rid of the thrombus, and you see the lining wall of the vein left behind; you put a little iodoform to it, and the thing heals up in a day or two, so that the patient has no further trouble.

One word with regard to ischio-rectal abscesses. The patient may have an abscess in the ischio-rectal fossa from various causes. It may be from internal causes such as ulceration, which is often tuberculous, or a fish bone, or a bone or a pin may have passed through the bowel and then become entangled in the sphincter, producing perforation; or it may arise from external causes, such as sitting on damp grass, on the wet seat of an omnibus, or things of that kind which have a tendency to produce local irritation and inflammation about the buttocks. From whatever cause it may happen the symptoms are much the same. The patient has a phlegmonous swelling, which is hot and tender, between the ischium and the anus, and the ischio-rectal fossa is filled up with inflammatory deposit, which rapidly becomes purulent. In a case of that kind the sooner you make an opening and let the matter out the better, for if it is allowed to remain it will burrow up into the rectum. The best way is to put the patient on his hands and knees, then to pass the finger into the rectum, left or right, according to circumstances; you then introduce a bistoury by the side of the rectum and cut outwards. You have the patient completely under your control by the finger in the rectum, so that you can hold him firmly, and you can put the knife down by the side of the rectum,

and just cut sufficiently to let the matter out freely. Then comes the question, Shall you do more? Shall you lay the abscess open into the rectum? That will depend upon how thin the rectum is. If the abscess has already encroached upon the rectum so that it is thin, it is better to lay it open at once into the rectum, because if you leave it, it will degenerate into a fistula, and you will be doing one operation instead of two.

You will know at once by the smell whether or not the abscess communicates with the rectum. Nothing is more offensive than the smell of pus in an ischio-rectal abscess which communicates with the rectum. In these cases there is no doubt about laying the bowel open; but in other cases, where it is a superficial abscess due to external causes, there will probably be no smell, and then I advise you not to lay the rectum open unless you have reason to think that it has been encroached upon.

Lastly, one word about hæmorrhage from the bowel. A patient comes to you and says: "I lose a little blood from the bowel, but I do not think it does any harm." That is perfectly true; an occasional discharge from the bowel is in many cases a salutary thing. You remember how the rectum is supplied with blood from the inferior mesenteric as well as from the iliac and pudic arteries, and that all the arteries inosculate, while the veins communicate with the vena portæ as well as the pudic veins, so that a slight hæmorrhage may in that way relieve a congested liver. But it is different if the patient loses considerable quantities of blood from the rectum; and you should always be on your guard to inquire whether the blood is simply mixed with the motion or whether it is spurted over the pan of the closet, because in the latter case it is obvious that it must be arterial blood or venous blood in considerable quantities shot out by the muscular efforts of the rectum. In either case the patient may lose more blood than is good for him. It may depend upon internal piles, and in the majority of cases it is so; but of the treatment of these I am not going to speak to-day.

There is one thing that causes hæmorrhage, and that is a vascular patch of mucous membrane in the rectum. When you expose it with the speculum you see blood pouring out from it. Those cases can be treated very readily by the application of caustic. They are the only cases of piles or rectal disease which really do well with caustic. To apply nitric acid to great masses of internal piles is really to play with them. But if on passing the speculum you can distinctly see a vascular surface, which bleeds very readily, I advise you to touch it freely with a piece of stick dipped in the strongest fuming nitric acid, or, as I prefer, the acid nitrate of mercury, the effect of which will be that you will arrest the hæmorrhage immediately. You should then lock up the bowels with a little

opium for a day or two to give rest, and the next time the patient has an evacuation there will be no bleeding, or, at least, much less; possibly another application may be required.

I will take another opportunity of speaking of hæmorrhoids, fistula, and so on. To-day I have merely gone through these minor matters, which, after all, are very important, both to the patient and the practitioner.—Christopher Heath, F. R. C. S., in *Br. Med. Jour.*

THE MEDICAL TREATMENT OF APPENDICITIS, WITH A REPORT OF FIVE CASES ENDING IN RECOVERY.

The diagnosis, symptomatology, and pathology of diseases in the region of the cæcum have been so recently and ably given by Drs. Price and Morton, members of the Society, that it would be useless for me to go over the ground again and attempt to add anything new on the subject. Surgery has made such marvelous advancement, and accomplished such brilliant results, in the last decade, that the medical treatment of certain diseases appears, at least for the time being, to be eclipsed. I am led to believe, from my limited experience, that some of our younger surgeons are too ready to perform abdominal section before they have exhausted the medical armamentarium, which, though perhaps somewhat slower, *may* be surer, and subject the patient to less risk.

I think the surgeon, in consultation with the physician, will be able to determine and select the cases for operation, if they are so fortunate as to see them in their incipency; but in many of these cases the physician is called in late, and the surgeon later—too late in some cases.

We are all more or less infatuated with the wonderful results of present surgery, because, I think, it is something tangible. We make our diagnosis of appendicitis, open the abdomen, and remove the diseased organ. There is the ocular proof of our skill in the diagnosis and operation. In medical treatment our evidence, if we can produce any, is not so conclusive. It is of a more circumstantial character.

No one of the same experience feels more deeply than I do the debt of gratitude we owe to aggressive surgeons, and no one, I think, takes the knife with more satisfaction; but I must always be *certain* that it is the *only* or safest method for the patient.

In the five cases which I wish to report, I demonstrated within twenty-four hours—in four of them, at least—that an operation was not necessary, and all the five recovered without section. You may infer that they were all mild or benign. Three of them were, because seen early and treated vigorously.

Perhaps the title of my paper is not broad enough to cover it, but I wish to include in the medical treatment of typhlitis everything short of surgical operations, for I rely as much, or more, on mechanical measures as on internal medication. I wish to report what I consider as the most critical case first, though it was my third in regard to date. The first case dates from March, 1889.

In four of the cases other physicians had been in attendance, or saw the patient with me in consultation. Two of the cases came to my notice late in the disease, and, to make the history complete, I shall be obliged to read parts of several letters which were kindly written to me by the physicians who first had the cases in charge.

For the previous history of the first case I am indebted to the kindness of Dr. Edwin B. Wheeler, who wrote me the following letter two months after treating the case:

"Was called to see Master A., thirteen years old, Thursday, April 2, 1890. He had been constipated a day or two, evidence conflicting as to the condition of the bowels previous to that time. There had been no diarrhoea, however. I first thought it a case of typhoid fever, as the father had just recovered from that disease. I ordered a powder of calomel, but no action. Then gave one bottle of citrate of magnesia in half-bottle doses, with no result. The pain and tenderness in inguinal region increasing. Some tympanites. Gave injection of tepid, soapy water, with a few drops of turpentine, without any result. On Friday I gave drachm doses of Rochelle salts in one-third of a glass of water every hour for four doses, and tincture of hyoscyamus. There was no result, so far as any action of the bowels was concerned. The vomiting was increasing, and the tenderness covering a larger area. During this time it had become apparent that we had to deal with an obstructed bowel, due either to intussusception, typhlitis, or perityphlitis.

"Injections on Saturday morning were not retained. Passed up a catheter, but still injection was not retained. Gave morphine in small doses. Saturday p.m., Dr. J. H. Cripps saw the case with me. We agreed as to the case, but were both on the fence as to the advisability of section. We then called in Dr. Noble, of the Kensington Hospital, Saturday, 6 p.m. After talking over the case, we concluded that the boy's best chance was to have the belly opened and the obstruction removed. We ordered a room cleaned, and agreed to see the case the next day.

"At 9 a.m. Sunday, April 6, we (Drs. Cripps, Noble, and myself) met, and concluded that the boy's chance would be slight if we operated in such unsanitary quarters, with such nursing as the father and mother could give. The parents agreeing, we wrote to the Pennsylvania Hospital,

asking them to take the case, the father to let me know the result of his errand. We separated with the understanding that if the hospital refused to admit him, we would operate, Dr. Noble saying he would hold himself in readiness until 2 p.m.

"About 11 a.m. the father informed me that the hospital authorities would send for the case as soon as I desired. I sent him back to the hospital with word to send for the case immediately. Somewhere about 3 p.m. the father informed me that he had been down town, but did not go to the hospital. He had stopped to see the boy's aunt, who said he should not go to the hospital. Whereupon I dismissed the case, refusing to have anything further to do with it. The case has certainly resulted very fortunately in your hands, and I am truly pleased, etc."

I will not go fully into the diagnosis of this case, for I was perfectly satisfied when I learned from the father, who had consulted in the case.

I was called in to the case at 10 p.m. Sunday, April 6. The symptoms all indicated complete obstruction of the bowels, and collapse. He had vomited first on Wednesday. The temperature was $96\frac{1}{2}^{\circ}$; pulse indistinct at wrist; heart was 140 per minute and he was in a cold perspiration; respiration, 40. Abdomen exceedingly tympanitic, and bladder much distended. There was stercoraceous vomiting, and nothing had been kept on the stomach for days. I at once gave a hypodermic of morphine, atropine, and strychnine, and then emptied the bladder by a catheter, and about sixteen ounces of water passed. The patient was apparently moribund, but revived somewhat after the hypodermic injection; and though I feared he would die while giving it, I knew there was no time to lose, and thought there might be a slight chance for life if the obstruction could be removed, so I had him supported in the knee-chest position, and injected a pint of warm liquid containing castor-oil, turpentine, whiskey, and Epsom salts. This was about 11 p.m.

This was kept in the bowel for half an hour by a compress, held in position by the hand; then he was allowed to lie down on the right side. Within an hour there was copious evacuation of liquid with scybalous masses. The injection was repeated at 12 o'clock, and another free movement resulted. These greatly relieved the tympany and pain. We then began to give turpentine and whisky by the mouth, once in two hours, and also a drachm of Epsom salts in hot water once in two hours alternately. Only the first dose of salts was rejected. The whisky and turpentine were retained. These were regularly administered through the night. I left the patient at 1 a.m. asleep, and he had become much more comfortable.

On returning in the morning, I found there had been several more movements, and the bladder had

been emptied naturally. The tumor over the right iliac fossa had nearly disappeared, and the pain and tenderness were much less. The temperature was normal. The tongue and sordes on teeth indicated typhoid fever. There were five movements of the bowels within twenty-four hours after the enema, and not less than three to six any day after for two weeks. The temperature gradually rose to 102° , and the evening temperature was about that for a week, when it gradually declined, but did not become normal till the 29th, or three weeks from the time I first saw the case. The stools had quite the appearance of typhoid, as did the tongue, and there was a suspicious eruption on the chest and abdomen. After the obstruction was removed the case was treated as a simple case of typhoid fever. He had 2 grains of quinine and $\frac{1}{30}$ of a grain of strychnine three times a day, with nitro-muriatic acid, pepsin, and bismuth every four hours, and paregoric when needed to control the bowels, and a liquid diet throughout.

At noon, the fourteenth day after I first saw him, after some pain and flatus, he passed a slough from the bowel, which, in the recent state, was elliptical and two and a half inches the long diameter. There seemed to be some pain and tendency to collapse, so he got another hypodermic and free stimulation. There was also a rise of 2° in temperature. He rallied the next day and made a rapid and complete recovery.

On May 6, which was just a month from the time I first saw him, he sat up and took solid food.

He is a strong, healthy boy, and now drives for me.

I watched the case very closely throughout, and feel certain that the intussusception, or typhlitis, or perityphlitis, was followed by a clear case of typhoid fever. I am by no means so clear in regard to the pathological condition in the region of the cæcum, and shall greatly appreciate the views of the members of the Society on that point.

The second case, Mr. M. K., who is a prominent and very active literary man in this city, dates from March 24, 1889.

The patient gave me a very intelligent history of his case, which was that there had been a gradual decrease in the evacuations for several weeks, with a great deal of distention and discomfort of abdomen, and finally obstinate constipation followed. When I first saw him there had been no movement for several days.

He had a tumor and localized pain in the right iliac fossa. Temperature $103\frac{1}{2}^{\circ}$. Pulse 120. Coated tongue, etc.

He was given a hypodermic of morphine and atropine for the pain, which gradually spread over the abdomen as the gas accumulated. Two large doses of castor oil and turpentine were taken without any action. He took calomel, soda and

ipecac powders for twelve hours, followed by Hunyadi water, but still there was no movement of the bowels. We then resorted to the enemata of turpentine, laudanum, castor oil, Epsom salts, and hot water, given in the knee-chest position. These moved the bowels freely and relieved the pain and distention. Turpentine stupes were also used freely.

There was a double inguinal hernia in this case, and to satisfy ourselves that there was no strangulation of the gut Dr. W. W. Keen was called in consultation, and pronounced the case free from any such complication, and confirmed the diagnosis of appendicitis. He suggested pills of colocynt comp. and opium.

The patient made a good recovery, and for several weeks took pills of aloin, strychnine, belladonna, cascara, and physostigma to relieve the atonic condition of the bowel, and an occasional dose of Hunyadi, as he was rather stout and full-blooded.

In July, or four months later, this same patient had a recurrence of the trouble while at the seashore, which began, possibly, with a slight tendency to constipation early, but the first the patient complained of was a severe serous diarrhoea with high temperature—104°. Pulse 128 (normal 58). Severe pain in the ileo-cæcal region. This attack began before I took up my summer practice at Cape May Point, and F. E. Stewart, of Wilmington, was called in.

He made the diagnosis of colliquative diarrhoea, and gave acetate of copper and morphine to check it, and aconite for the fever, but nothing seemed to have any permanent control over the bowels.

Right here in this case, which was my first patient, but his second attack of appendicitis, I learned a very valuable lesson. Here was an obstructed bowel, and nature was trying, by pouring out a very excessive liquid secretion, to flush out the obstruction of foreign matter.

I simply took the cue from nature, and with small, frequently repeated doses of calomel, ipecac, and soda, followed by salines, accomplished the object, and in less than six hours had the satisfaction of seeing the tumor, which had been in the region of the cæcum, deposited in a commode, which the black, very offensive mass nearly filled. In this attack we used hypodermic injections of morphine for pain, and pilocarpine for the high fever and dry skin and tendency to cerebral congestion, as the kidneys were not acting at all freely. There was no vomiting after the first hypodermic, and the patient began at once to take iced champagne and Apollinaris, and soon was able to take milk and other liquid food.

In this case no resort was had to rectal enemata, as the bowels were thoroughly cleared out within six hours after the time I first the patient, and in three or four days he was attending to his regular

business. He took the aperient, tonic pills for several months, and was requested to use Hunyadi water freely, and rectal injections, if the symptoms occurred again. He has had no recurrent attacks and no constipation since.

The fourth case, Miss S., occurred at Cape May Point, and was first seen and treated by Dr. F. E. Stewart, Wednesday, August 25, 1891. I wished to speak of this case at the special meeting, September 28, when Dr. Morton read his interesting paper on "The Surgical Treatment of Appendicitis," and wired Dr. Stewart for his diagnosis, and he sent me the following telegram: "Case was obscure. Called Dr. David Stewart in consultation. He said 'appendicitis.'" I am indebted to Dr. F. E. Stewart for kindly furnishing me the history of this case, which I quote from his letter:

"In the case of Miss S., there were pain and tenderness over the abdomen, which, as the case developed, became marked in or over the right iliac fossa. Instead of dorsal decubitus, the patient sat in a chair with her thighs flexed on the abdomen, and could not lie down until relieved by treatment. There was fever; temperature 102°. There was constipation, nausea, and, if I remember correctly, some vomiting, but the latter was not a marked symptom of the case. I did not discover a tumor on abdominal palpation or vaginal touch; but Dr. David Stewart, who saw the case with me on the second day, called my attention to what appeared to be a doughy mass on the right side of the body on examination *per rectum*. I must confess that I would not have discovered said mass except my attention had been called particularly to it, or in other words, I might have had a suspicion of its existence, but it required a finger of more education than mine in feeling for tumors of this nature to make a positive diagnosis.

"The treatment suggested consisted of hot turpentine stupes, opium, and iodide of mercury; under this she seemed to improve.

"From the beginning I recognized the gravity of the case. I advised her to go to the city at once, as proper nursing was out of the question, situated as she was at the Point. Furthermore, I told her if she got worse an operation might become necessary, and then it would be too late to remove her."

I first saw the case Monday, August 31, at 6.30 p.m., and found her extremely weak and nervous from the trip from Cape May Point. The temperature was 103½°; pulse 120; abdomen tense, tympanitic, and extremely sensitive. I found a large tumor in the region of ileo-cæcal valve, intense pain and nausea. * There was extreme tenderness over the tumor and the abdomen generally, indicating a good deal of general peritonitis.

Miss S. was brought to the city by her sister-in-

law, and they went into a house where the furniture had just been piled in. There was not even a bed up, or any convenience for heating water, so, in regard to nursing and environment, she did not improve her condition. When I arrived she was on a bed that had been hastily put up.

The sister-in-law, who acted as nurse, got hot water for stupes and enemas, and the patient had the same treatment, practically, as the boy—the first case reported—except that I entrusted the giving of enemata to the nurse, who proved very intelligent and efficient.

When I called the next morning I found the bowels had moved freely several times, and, though the patient had had a restless night, she had slept some. The pain and distention were nearly gone, and the temperature had fallen to 101°. By Wednesday, September 2, the temperature was normal, and the pain was entirely gone. She began sitting up Thursday, without my knowledge, and the next Wednesday she went back to the Point. I believe she had a slight recurrence of the pain, inflammation, and constipation the week after she got home, but they were controlled by injections, stupes, and opium suppositories.

She has enjoyed good health since.

The other two cases of typhlitis, which occurred in my practice within the last year, were quite similar in regard to symptoms and treatment to the others that I have reported in detail, and as I relied only on myself for the diagnosis and treatment, I will not weary you with a repetition of them. I have not aimed to give the latest and most approved treatment from the text-books of the day, but what seemed to me to be indicated and necessary in the emergencies of these cases, when I dared not waste a moment in temporizing or experimenting. It appears to me a serious loss of time to depend solely on external applications to the abdomen, and protiodide of mercury, with belladonna and opium, internally, when we have to deal with a bowel obstructed by hardened accumulation of feces. I believe most cases of obstruction of the bowel, if not due to intussusception or strangulated hernia, are due to the absence of the natural secretion caused by the localized typhlitis, which, if not relieved, becomes a perityphlitis, and then more or less general peritonitis must result. The rational method seems to me to be:

1. To relieve the pain by hypodermic injections.
2. To remove the cause or obstruction by causing, if necessary, pathological or excessive secretion, by giving some saline, which I believe is the best antiphlogistic for the inflamed bowel.
3. To soften the hardened fecal accumulation from below with enemata, solution of Epsom salts in water as hot as can be comfortably borne, to which I add turpentine and oil.

The knee-chest position, with copious enema,

favors the distention of the colon up to the seat of the disease.

I have found by experience that the enema to be effective must be given in this position, and that it must remain in the bowel for some time, and in several of my cases it was necessary to repeat the operation three or four times. This plan of treatment has been successful in six cases, which are all that I have treated; but I fully realize that it may fail in the seventh.

I think it is truly in meetings like this that surgeons are broadened medically and physicians surgically—if I may be allowed the phrase. Doctors are only human, as we hear it said of ministers, and as such they are prone to do what they prefer, whether it be surgical or medical, and naturally they do best what they like to do and do oftenest.—A. B. Kirkpatrick, M.D., in *Times and Reg.*

TREATMENT OF DIPHTHERIA BY IRRIGATION WITH SALICYLIC ACID.

Parisot, of Thillot, in Vosges, has published in the *Bulletin Général de Thérapeutique*, an article in which he highly commends, in diphtheria, the employment of irrigations of salicylic acid (1-1000), and affirms that whereas before resorting to this method of treatment the mortality from that disease as occurring in his practice was large—ten cases out of every fourteen in a recent epidemic in which he has relied on the irrigations there were only five fatal cases out of every twenty-four.

The formula which this writer employs is as follows:—

R—Acid. salicylic, 1 gm.
 Water, 980 gms.
 Alcohol (90%), 20 “—M.

Dissolve the salicylic acid in the alcohol, and add the water.

The apparatus which he uses for the irrigation is simply a fountain springe with the “recipient” or “fountain” of tin; this fountain is hung on the wall over the patient; the rubber tubing which is connected with the lower extremity of the fountain, ends in a small glass tube tapering at the point like a dropping-tube. A spring “catch” on some part of the tubing interrupts the current of liquid at will. When the fountain is charged with the solution and ready for action, the head of the child is held by an assistant, the tongue depressed, and the jet directed into the mouth and posterior pharynx with sufficient force to detach and remove the false membranes if they happen to be loose.

Parisot likes best the position in which the child is held with the head forward and a little downward. Where the child is very feeble, it may be supported upon the arm of the assistant with the

face turned toward the floor. In this position it may be more difficult to perform the irrigations, but there is more certainty that the liquid will flow back again, and not be swallowed in any quantity.

As for the quantity of the liquid to be used in each irrigation, this must be left to the judgment of the physician; it may not amount to more than three or four ounces each time, but in grave cases the oftener the irrigation is practiced the better. The use of the irrigations does not make unnecessary other remedial measures, such as the frequent administration of stimulants.

Pariset makes some remarks as to the action of salicylic acid on false membranes which, if true, are of great practical importance. He believes he ascertained by experiment that this acid is destructive to diphtheritic formations; in distilled water, the false membrane was simply disaggregated, and this disaggregation took place slowly, while in solutions of different strengths of salicylic acid the exudate disappeared rapidly; at the end of a few minutes, nothing was found but the meshes of the net-work serving for support to the bells of the exudation. The stronger the solution of salicylic acid the more prompt and complete was the disappearance of the exudate.

Pariset, has, moreover, noticed that in diphtheritic throats that have been irrigated with the salicylic solutions, false membranes, when once detached, are reproduced more slowly and imperfectly than when the throat is cleared by any other process; he hence concludes that the mucous membrane is favorably modified by the salicylic acid, and rendered unfit for the reproduction of the diphtheritic patches, and hence for the culture of Loeffler's bacillus.

Salicylic acid in weak solutions has been often employed locally in cases of diphtheritic angina. Berthold, of Dresden, derived benefit from such applications in stomatitis, thrush, and diphtheritic sore throat. Moizard and Bergeron claimed success from the use of this remedy, and Goutheim, out of thirty-one cases treated by swabblings with salicylic solutions, did not lose a patient. D'Espine and Picot have also treated several cases by irrigations with solutions of varying strength, and have been pleased with the results.

Weise was one of the first to advocate the topical use of this acid in diphtheria. His method is to begin treatment by painting the throat with a tolerably strong solution, then he causes a weak solution to be inhaled; half an hour afterward he gives the patient a swallow of wine; in another half-hour, a spoonful of a strong solution of benzoate of soda, then a little more wine, and when two hours comes around the series begins again with swabbing or gargling with the salicylic solution. The result of his success, according to Guelpa, from whose paper we quote, is, that he does not

let half an hour during the day elapse (the interval is a little longer during the night) without irrigating or otherwise cleansing the throat of the patient with some efficient antiseptic substance, wine, solution of salicylic acid, or benzoate of soda. To many the profit of so much meddling, either locally or constitutionally, will seem doubtful.—*Coll. and Clin. Rec.*

CHRONIC GASTRITIS TREATED BY LAVAGE.

The man before us is 49 years of age, and was admitted to the Hospital on September 1, 1891, complaining of very severe colicky pains in the abdomen. The pain, which was evidently due to catarrh of the small intestines, was relieved by small doses of epsom salts and laudanum. He continued, however, to complain of epigastric pain, and, upon careful questioning, it became apparent that he had suffered for some months with severe attacks of pain and vomiting. The ordinary methods of treatment were tried; he was placed on bismuth and calomel in small doses; he had daily doses of Carlsbad salt (3j to 3j of hot water); diet was regulated and for several days his food was restricted to peptonized milk. But, in spite of this treatment, he continued to complain of pain, and vomited about once a day. Seeing how utterly futile the above treatment was, it occurred to us that digestion was probably rendered difficult or impossible by an accumulation of mucus in the stomach, and that it would probably be necessary to cleanse the stomach of this before we could hope to attain any marked relief.

Experience has shown that a soft rubber tube can easily be swallowed by a patient who is willing and anxious to co-operate with the physician, and who is not very nervous or irritable. This patient has already swallowed the tube two or three times, and you see, as my resident, Dr. Miller, passes the tube well back on the epiglottis and asks him to swallow it, it passes down the œsophagus naturally and without apparently causing the patient any marked discomfort. As it passes the epiglottis and compresses slightly the posterior portion of the larynx, a slight choking sensation is generally experienced, but with the descent of the tube, this sensation gradually passes off. The tube is now in the stomach, and Dr. Miller proceeds to pour directly into the stomach, through the funnel at the upper end of the tube, the alkaline solution (about half an ounce of bicarbonate of soda to one quart of water). After the stomach is full, depressing the funnel causes emptying of the stomach by siphonage. This process is gone through with every second or third day.

There is no question that the long continued

use of lavage may be injurious, and may tend to impair the function of the peptic glands, but in some cases, the first effects in relieving the patient of distress and enabling him to digest food, which he for weeks has been utterly unable to do, are certainly most encouraging. The patient feels much better after this treatment. For two or three days he has had no food at all by the mouth, and was put entirely upon nutrient enemata consisting of the white of an egg, ʒj of Carnrick's beef peptonoids in powder, and ʒvj of peptonized milk. You know that in introducing food into the bowel, it is important to peptonize it, because the glands of the rectum absorb, but do not, except perhaps in a very feeble degree, peptonized food. The bowel is thoroughly washed out by an enema of soap and water, once a day, about two hours before the nutrient enema is introduced; and, to prevent excessive irritability of the rectum and secure attention of the enema, about one-sixth of a grain of morphine sulphate is added to the enema. Yesterday, he was put upon a small amount of milk. To-day, he tells us that he feels a great deal better. He complains somewhat of hunger, and, I think, he can now digest much larger amounts taken by the mouth. I hope he will gradually be able to live as do other people; however, it is not impossible that there may be, in this case, some obstruction at the pyloric orifice.

We may have here to deal with a case of dilatation of the stomach, brought on by long continued gastric catarrh. Further study of the case will doubtless throw light on this point, but, in any case, we must be prepared to expect a very slow recovery, as this condition is one that has probably been gradually developing for years past, and the whole nutrition of the mucous membrane of the stomach is altered, and it may take months to restore the normal conditions, if, indeed, they can ever be completely restored.—*Med. and Surg. Rep.*

THE PATHOLOGY AND TREATMENT OF PUERPERAL ECLAMPSIA.

It is not long since the subject of puerperal eclampsia was ably discussed before the New York Academy of Medicine, and the views at that time expressed were laid before our readers. But it cannot be said that positive conclusions have yet been reached regarding this important topic, and we believe that the discussion on puerperal eclampsia, which took place before the British Medical Association last July, will interest our readers.

Dr. A. L. Galabin, of London, opened the debate. He showed that there was a pretty general uniformity of belief that the convulsions are due to some kind of renal impairment. But he showed that this does not quite solve the problem, since

it is necessary to know what causes this renal disease. The experiments of Dr. Blanc were cited as indicating that in the urine of eclamptic patients there is a specific bacillus which when cultivated causes convulsions in some lower animals. Dr. Blanc thinks that this bacillus causes not only the nephritis, but also the convulsions directly. Bearing on this point Dr. Byers cited the investigations of C. Leyden. This observer examined the kidneys of three fatal cases in which there was eclampsia associated with albuminuria, and found "the kidneys large and pale, and cortex yellowish and dull. Microscopic examination showed a very extensive loading with fat, especially in the tubuli contorti; to some extent also in the glomeruli and in the Malpighian capsules. The fact was distinctly present in large drops." When the kidneys remained for a time in spirits the fat in great part disappeared, and then the organs, on microscopic examination, appeared to be normal; and accordingly he infers that this fatty condition is not a degeneration, but an infiltration. His view is that such morbid conditions are due to a prolonged arterial anemia. He thinks it also explains the rapid recovery that so frequently follows delivery. Further, he regards causes as the changed conditions of pressure which affect the abdomen or the effluent urinary organs.

Dr. Auvard's view that eclampsia is the result of a "strike" on the part of the organs of elimination, especially the kidneys, no doubt represents a truth, but hardly goes deep enough to be called a scientific explanation.

The same may be said of the theory of Stumpf, that under certain circumstances a nitrogenous substance of a toxemic nature—it may be acetone or a closely allied body—is developed, which in its elimination irritates the kidneys, and so causes a nephritis.

It seems that we do not know as yet more about the pathology of eclampsia than that there is some convulsive poison thrown into the blood, either through renal disease or infection or both.

The subject of therapeutics of eclampsia is more interesting, though here also no great unanimity of opinion was reached. According to Dr. Auvard, the mortality from no treatment at all is only twenty-five per cent. while that following active interference is thirty-one per cent. Nihilist therapeutics should make a note of these figures. Dr. Galabin, however, gives the percentage of mortality at Guy's Hospital under venesection as thirty per cent., while under the use of chloroform it was 20.5 per cent. These figures, however, do not do justice to venesection, since they apply to the period when antiseptics was not used. Dr. Galabin himself favors venesection in certain cases, especially venesection in large amount (forty ounces). Auvard's mortality with venesection was thirty-five per cent. Dr. J. G. Swayne, in an

experience with thirty-six cases found venesection is the most efficacious remedy, chloroform and chloral next, and delivery third. Most of the other speakers recommended chloral and chloroform, and venesection in plethoric cases. Little reference was made to the use of morphine or hot baths or pilocarpine, and on the whole we should say that English physicians depended chiefly on the chloral-chloroform treatment. The morphine treatment, which may be considered especially an American one, is evidently but little used.—*Medical Record*.

MEDICAL NOTES.

A mixture of one part each of lactic acid and salicylic acid in eight parts of collodion is recommended as an excellent application to *Corns* and *Warts*, effecting their removal in a short time.

As an *Expectorant Mixture*, *Semaine Medicale* recommends the following:—

R—Apomorphiæ hydrochlorat., gr. j.
Morphiæ sulph., gr. ss.
Acid, hydrochloric, dil., gtt. x.
Aquæ destillat., f ̄ 3 v.—M.

Sig.—Teaspoonful every two to four hours.

Dr. S. E. Milliken, in a paper on *The Treatment of Hydrocele by Carbolic Acid Injection* (*Annals of Surgery*, October, 1891), concludes that carbolic injection is a safe method for its cure; is practically painless; the patient can attend to business without more than one day's delay; and the disagreeable effects of an anæsthetic are avoided.

For *Eruclations* and belching of gases, caused by atonic or subacute gastric catarrh, the following has been suggested (Dr. H. A. Hare):—

R—Oleoresin capsici, gtt. x-xx.
Pancreatin, gr. xx.
Zingiberis pulv.,
Carbon. ligni pulv., āā gr. xl.—M.

Fiant pil xx.

Sig.—One t. d.

Dr. S. E. Solly (*The Climatologist*, September, 1891), in a paper on "*The Personal Equation in the Treatment of Phthisis*," draws the following conclusion from cases under observation: If, as would appear from the comparison made with the other reports of cases treated in high climates, these 141 cases represent the average qualities of such cases, then the truths indicated by these inquiries are that the qualities which most aid the consumptive in recovery are, first, strength; second, wisdom; and third equanimity. Therefore, the essentials of the great treatment of phthisis are to preserve and strengthen the physique, enforce prudence, and induce placidity.

The following has been used with success in *Hæmoptysis* (*Gaceta Sanit. de Barcelona*, in *Cin. Lancet-Clinic*).

R—Essent. terebinth.,
Ol. Amygdalæ, āā gms. 5 (f ̄ 3j ̄)
Mucilagin, acaciæ,
Syrup simplic., āā gms. 20 (f ̄ 3 v.)
Aquæ destillat. gms. 200 (f ̄ 3 vij).—M.
A teaspoonful every half hour.

Donovan's solution of iodide of arsenic and mercury is said to be of material service in the treatment of *Gleet* (*Medical Record*). It is given for this purpose in the dose of ten minims, three times a day. A correspondent writes that he feels justified, so uniform has been his success in controlling a chronic eurethral discharge by Donovan's solution, in calling the remedy almost a specific for *Gleet*.

Dr. E. Zimmermann (*Med. News*), states that he has used with signal success the following formula as a topical application to the throat in the treatment of *Malignant Diphtheria*:—

R—Acid, sulphurosi, f ̄ 3 ss.
Liquor. potassæ, gtt. xi.
Aquæ calcis, ad. f ̄ 3 iv.

Mix, filter; keep well corked, in a cool place. To be applied topically to the throat by means of a sponge, probably every hour or two.

Chloride of Methyl spray (*British Medical Journal*), can be employed in all cases where an ether spray is used as a *Local Anæsthetic*, and should be preferred to the latter, since, 1. It induces anæsthesia incomparably more quickly than ether spray. 2. It is unflammable, and hence can be employed more safely than ether for cauterization, etc. 3. It does not undergo any change from exposure to light or air. 4. It does not irritate mucous membranes, even in children. 5. It is cheaper than ether, since only very small quantities are required.—*Coll. and Clin. Rec.*

ARSENITE OF COPPER.—My attention was first called to the preparation in the issue of the *New York Medical Journal* of August 16, 1890, in the letter of Dr. Branch Clark, who said that he had not lost a patient with cholera infantum since he began its use, and that he used it in cholera infantum, cholera morbus, and dysentery, with uniformly good results.

I will give you briefly some of my experience with the preparation. I would say, first, that in cases of cholera infantum and cholera morbus it very often relieved the vomiting before it relieved the diarrhœa.

The first case I tried it on was that of a bottle-fed child, aged six months. It was taken with fetid diarrhœa, the stools being of the "frog-pond"

variety. I first gave fractional doses of calomel, followed by bismuth subnitrate and pepsin, without any relief, the diarrhoea continuing for two days. I then dissolved a tablet containing one one-hundredth of a grain of the arsenite of copper in four ounces of water, and ordered a teaspoonful to be given every ten minutes for an hour, then every hour until the patient was relieved. I heard nothing of the child for two or three days, and, on inquiry, the parents said they feared the diarrhoea had been checked too suddenly, as the child had not had a passage after they began the last medicine until that morning. They had thought of giving it a dose of castor oil, the bowels having been checked so suddenly.

I gave it to another child, aged twenty-two months, that had been given homeopathic medicines for several days without benefit, and was vomiting and purging about every half hour or hour, when I was called. I gave it the same dose in the same way as in the other case. The child did not vomit any more, and the bowels moved only three times in fourteen hours after the first dose was taken; after that the bowels moved normally.

Another child, aged twenty-one months, has been treated for diarrhoea for about two weeks; the passages had numbered twenty-two in the twenty-four hours preceding the time I first saw it. I gave it the arsenite of copper in the same way, and the child was relieved without further trouble.

A few weeks ago, during one night and the next day, I treated ten severe cases of cholera morbus with the arsenite copper. The youngest patient was a lad of ten, the oldest a man of about sixty-five years. The lad was vomiting and purging violently when I reached him. I tried at first to give him bismuth subnitrate, but it failed to relieve the nausea and vomiting, and he had to rise every few minutes on account of the purging. I then gave him the arsenite of copper in the above-mentioned dose, and his nausea and vomiting were relieved after the first dose; the bowels moved only twice after the first dose was taken.

Another patient, a man aged about fifty, was vomiting and purging very violently; I gave him arsenite of copper in the above-named dose, and his vomiting was relieved at once and the purging very quickly. This man had weighed himself the evening before, and found his weight to be two hundred and sixteen pounds. The next morning, after the attack of cholera morbus, he again weighed himself and found he had lost seven pounds and a half during the night.

In the other cases I have the arsenite of copper in the same dose alone, with uniformly good results. In all these cases I found the arsenite of copper would relieve the soreness of the bowels in a very few hours. I have tried the remedy in

one case of chronic diarrhoea, where all the remedies I had given before failed to give relief. The man was very much emaciated, and since taking the copper arsenite has gained very much in flesh and strength. I gave him the one one-hundredth of a grain at a dose, repeated every three or four hours.

I certainly can bear testimony as to the value of the arsenite of copper in my hands in all cases of acute diarrheal disease.—Wm. J. Brnd, M. D., *N. Y. Med. Journal.*

INEBRIETY.—In most cases inebriety is a self-limited disease. The drink symptom dies out naturally, or concentrates in some other form of morbid impulse. Any remedies or means used at the time of change will be credited as curative. The cessation of the drink impulse is not followed by full restoration, yet the impression prevails that total abstinence is a sign of cure always. Many pronounced paranoias and diseased persons who have abstained from alcohol, are posing as examples of cure from this or that means or remedy—persons in whom the drink impulse has died away naturally, no matter what remedy may be used. This is evident in the common class of those who sign the pledge, or profess conversion, many times, only to relapse after each occasion. Finally, in apparently the same circumstances, they go through the same formula, and the drink impulse disappears forever.

The real facts are that some organic brain change has taken place, the desire for alcohol ends. Other morbid symptoms may come on, but this disease has subsided or taken on new forms. The bark remedy, the mind cure, hypnotism, or any of the so-called specifics, that are followed by a cessation of a drink impulse, are all examples of this change. Physicians of asylums recognize this, and direct all their efforts to build up and bring the patient back to a normal physiological life, in expectation of the final cessation of the drink symptom and restoration of the organic processes. This result may come on any time, and the object of all treatment is to encourage this, and remove the conditions which seem to provoke the drink symptom.

Drugs or restraint which holds the drink symptom in abeyance are never curative, and when followed by a subsidence of this impulse, it is an accidental conjunction of the natural dying away or change of brain function and growth. When such change occurs after long treatment in the best physiological and hygienic conditions, it is reasonable to suppose that these means have contributed more or less to this end. But when this subsidence follows in conditions opposed to this, and from means inadequate to change or alter organic action, clearly some other forces are at work.

The self-limitation of inebriety, and the natural

history and progress of the disease are yet to be written.—*Quarterly Journal of Inebriety.*

THE LACTIC ACID TREATMENT OF DIARRHŒA.—In a number of cases of diarrhœa due to various causes, including phthisis, typhoid fever, erysipelas, and intestinal catarrh, which Dr. Shchegoleff, according to a paper he has published in the *Meditsinskoe Obozrénie*, treated by means of lactic acid, a successful result was obtained in two days in fifteen, in three days in five, and in four days in three. In twelve cases of exanthematous typhus the treatment failed to have effect, but in thirteen others it was successful. The preparation used was an aqueous solution sweetened with syrup. In this form the drug was well tolerated, and no unpleasant symptoms were produced. The quantity of lactic acid given per diem averaged about 115 grains, or little more than half that given by M. Hayem, who first recommended this treatment, and this may perhaps account for some of the failures of the Russian practitioner. Acting on the advice of the latter, Dr. Chernisheff, who has also published an account of his cases, prescribed lactic acid in three cases of acute intestinal catarrh, in six of chronic gastro-intestinal catarrh, also in eight of diarrhœa due to phthisis, and in three of diarrhœa complicating Bright's disease. In all these cases good, sometimes striking, results were obtained. Thus several cases of simple catarrhal diarrhœa were relieved in from two to five days. In six cases of non-specific diarrhœa in phthisical persons the diarrhœa ceased the day after the commencement of the treatment. In one case of chronic gastro-intestinal catarrh the diarrhœa ceased on the third day from the commencement of the lactic acid treatment, but reappeared when it was stopped. Two days more of the treatment served to effect a more permanent cure. Notwithstanding the observations of M.M. Hayem and Lesage on the value of lactic acid in the diarrhœa with green stools of young children (see *The Lancet*, Vol. i. 1887, p. 1149, and Vol. ii. 1887, p. 1020), according to whom lactic acid destroys the bacillus on which the condition depends, this medicament is rarely used, and, indeed, is not generally known to have any effect on infantile or other diarrhœa.—*Lancet.*

THE COUCH—A ROOM IS ONLY HALF FURNISHED WITHOUT ONE.—A room without a couch of some sort is only half furnished. Life is full of ups and downs, and all that saves the sanity of the mentally jaded and physically exhausted fortune fighter is the periodical good cry, and the momentary loss of consciousness on the upstairs lounge, or the old sofa in the sitting-room. There are times when so many of the things that distract us could be straightened out, and the way made clear, if one only had a long comfortable couch, on whose

soft bosom he could throw himself, boots and brains, stretch his weary frame, unmindful of tidies and tapestry, close his tired eyes, relax the tension of his muscles, and give his harassed mind a chance. Ten minutes of this soothing narcotic, when the head throbs, the soul yearns for endless, dreamless, eternal rest, would make the vision clear, the nerves steady, the heart light, and the star of hope shine again.

There isn't a doubt that the longing to die is mistaken for the need of a nap. Instead of the immortality of the soul, business men and working women want regular and systematic doses of dozing—and after a mossy bank in the shade of an old oak, that succeeding Junes have converted into a tenement of song birds, there is nothing that can approach a big sofa, or a low, long couch placed in a corner, where tired nature can turn her face to the wall and sleep and doze away the gloom.—*Med. and Surg. Rep.*

MORALITY ACCORDING TO OCCUPATION.—At the recent Congress of Hygiene and Demography, Mr. Ogle (*Med. News*) presented statistics as to the comparative mortality among those between twenty-five and sixty-five years old engaged in the various occupations in England. The death-rate among clergyman being the least, this was taken as a standard of comparison. The following table presents the comparative mortality:

Clergyman.....	100	Wool-workers.....	186
Gardeners.....	108	Armors.....	186
Farmers.....	114	Tailors.....	189
Husbandmen.....	126	Hatters.....	192
Papermakers.....	129	Printers.....	193
Grocers.....	139	Cotton-workers.....	196
Fishermen.....	143	Clerks.....	199
Cabinetmakers.....	148	Physicians.....	202
Lawyers.....	152	Quarrymen.....	202
Brushmakers.....	152	Bookbinders.....	210
Mechanics.....	155	Butchers.....	211
Tradesmen.....	158	Glassmakers.....	214
Woolen-drapers.....	159	Plumbers, painters, etc.	216
Milliners.....	160	Cutlers.....	229
Shoemakers.....	166	Brewers.....	245
Commercial travelers.....	171	Ominbus-drivers.....	267
Bakers.....	172	Wine-merchants.....	274
Millers.....	172	Bass-singers.....	300
Upholsterers.....	173	Potters.....	314
Masons.....	174	Miners.....	331
Smiths.....	175	Hotel-waiters.....	397
Laborers.....	185		

—*Cincinnati Lancet-Clinic.*

THE POPULAR PHYSICIAN.—He is a highly entertaining sort of being, is the gentleman we are about to introduce. Many of our readers, no doubt, may have met and conversed with him, and all must have heard of his fame. He is altogether fascinating and unique, yet withal so condescending. He is one of those men who will enter, heart and soul, into everything, and that without being invited, and he *knows* a little about *nearly* every-

thing! Nothing is above his notice and very little is beneath it. He is versatile, humorous and entertaining, but above all popular.

His name is constantly before the public in some connection or other, and it is a crisp, catchy sort of a name, a double name generally, and having perhaps an alliterative sound about it, a name, in fact, that sticks in the public mind and looks imposing at the bottom of a "Letter to the Editor," in a lay newspaper. And that is where the P. P. is so agreeable and condescending, he does not disdain to write to the papers. No matter what the subject, so long as he can on any pretext give to it a quasi-medical or scientific aspect, he is very much all there. He has a theory and he gives it to the public for nothing! He will even give "advice gratis" on occasion, and tell us all about the therapeutic treatment of some epidemic or other fashionable disease. He is, indeed, the very oracle of popular medicine; but that is not all, as we said before, he is up in *everything*!

Is it an assassin who has long evaded the police? Our friend is ready with his theory, and springs it on the delighted editor of an evening "ha'p'orth." Is it the appearance of a new music-hall "phenomenon?" He turns up in some other quarter with a long-winded original explanation. Is there a new soap out? He approves of it. Has there been another pet sensation murder? It has some psychological interest or significance, which has occurred only to his broad and versatile intellect, and has "quite escaped the notice of your readers;" there was some vague motive for the crime, perhaps, and he alone has discovered it; or the perpetrator is a lunatic, poor wretch, and the P.P. will tell us how he has proved this conclusively, without having even seen the accused.

There is no limit to his condescension and good nature. He will sometimes speak at a public meeting, and he is quite sure to meet with an enthusiastic welcome. It is rumored that he is not unwilling to sit on the County Council, and we devoutly hope that he may get there!

And then there is his practice, which is necessarily a large one. The old ladies just dote upon him, and he doesn't seem to mind it the least bit. Wherever he is called in there is the universally expressed opinion that he is such a "nice doctor;" you seldom hear any other expression made use of, and this one just describes him, he is nothing if not "nice." He has acquired considerable knowledge of veterinary surgery and lap-dogs, and he has been known to betray a lurking tendency towards homœopathy. It need hardly be told that this gentleman is possessed of a considerable income, and an entire pew in his parish church. He has a wife—a lady of brilliant conversational power—who knows a good deal about his profession, and all about the numerous smart patients her husband goes to visit; she is naïvely communi-

cative on these matters. Needless to say she is asked out everywhere, and she goes.—C. K. J., in *Hosp. Gaz.*

THE ORIGIN OF CHOREA.—Chorea bears in many respects a great resemblance, in its onset, course, and general characters, to the group of infective diseases. In man it most frequently follows or accompanies acute articular rheumatism; it generally occurs in children aged from four to twelve years, which is the age at which there seems to be a special predisposition to infective diseases; it generally runs a definite course, and even without treatment tends to disappear after a certain period of time. These facts led Dr. Pianese to make an examination of the disease from a bacteriological point of view, and he now publishes (*Riforma Medica*, July 14th, 1891), a preliminary communication on the subject. After seven months' work, he has come to the following conclusions: (1) From the cervical portion of the cord of a patient dead of chorea he has succeeded in isolating a bacillus, which grows on the usual culture media between 20° and 38° C., develops gas when cultivated in gelatine, grows on bread paste, shows slow movements when grown in a hanging drop, forms spores, and can be stained well with carbo-fuchsine. (2) Inoculation of this bacillus into guinea pigs, dogs and rabbits, whether subcutaneous, intraperitoneal, or intravenous, always gave negative results. (3) Inoculation under the dura mater, either of the cord or of the sciatic nerve in six dogs and thirteen rabbits gave a positive result. Inoculations into the nasal mucous membrane of four guinea pigs were also successful. (4) Inoculations into the anterior chamber of the eye in rabbits succeeded in two out of three cases. (5) In the successful cases the symptoms produced were as follows: A tremor, sometimes general and at other times confined to special groups of muscles, particularly those of the back and shoulder; the animals became extremely irritable, even to trifling disturbance, and cried out when touched along the vertebral column. These phenomena generally appeared twenty-four hours after inoculation, and became more marked in the following days; there next appeared contracture in one or other of the limbs, and the gait became more and more uncertain and difficult; the animals got very thin and generally died on the fourth day. Guinea pigs inoculated in the nasal mucous membrane generally died in twenty-four to thirty-six hours; the dogs and rabbits inoculated in the sciatic, however, recovered completely after presenting during twenty to thirty days a general tremor, with contractures and progressive wasting. (6) In the animals which died after inoculation, bacilli were found only in the brain, cord and nerves, and cultures could be obtained from these parts. (7) The ganglion cells, especi-

those of the anterior cornua of the cord showed changes in their protoplasm quite similar to those met with in cases of chorea. (8) In association with the red blood corpuscles of the vessels of the spinal cord in a choreic patient he found bodies clearly bacillary in nature, some exactly similar to those of the cultures, others apparently being involutions forms. Dr. Pianese is continuing his researches, and hopes soon to be able to bring forward further confirmatory evidence as to the real bacillary nature of chorea.—*Br. Med. Jour.*

COCAINE IN VOMITING.—M. W. Everson, M.D., in *College and Clinical Record*, calls the attention to the special merit of cocaine in nausea, particularly in that of pregnancy, gastric ulcer and cancer.

"In vomiting of pregnancy $\frac{1}{2}$ to $\frac{1}{4}$ grain three times daily will generally be sufficient. Cocaine will be found of value where other remedies fail. I have found it successful in those cases of vomiting of pregnancy in which the so-called specifics, oxalate of cerium, etc., have failed. In gastric cancer it will often arrest the vomiting for days at a time, thus giving the stomach rest and allowing more perfect attempts at nutrition. In every case in which it was used the vomiting and pain were noticeably lessened, and the patient was made vastly more comfortable. But, regardless of the above special diseases, cocaine is of use in vomiting from any cause; and there are many cases attended by vomiting met with by the practitioner of medicine for which no cause can be immediately assigned. In these cases its action is manifested at once, and after the first dose the vomiting usually ceases. The most desirable way to administer cocaine is in pill form, but it may be given in solution when a proper vehicle is added. Cocaine can be given in suitable doses without fear of depression; indeed, it can be given to a double advantage where a weak circulation exists, as it is to some extent a circulatory stimulant. It is also of use in vomiting of enterocolitis of children, a disease which is so frequent in our large cities during the heated term, and in which vomiting is so prominent a symptom. In the latter affection it is best given in combination with bismuth. To a child two years of age I give $\frac{1}{8}$ grain of the hydrochlorate at a dose, and repeat it every few hours, *pro re nata.*"—*Pharm. Record.*

THE ACTION OF CHLORAL HYDRATE ON THE KIDNEYS.—Since the publication of Liebrich's monograph on chloral, there has been no study of the action of this remedy on the kidneys sufficient to explain results which had been sometimes noted to follow the use of this valuable hypnotic. Dr. Cavazzini has, however, recently made some experiments in this connection on dogs and guinea pigs, and he has found that when injected into the

abdominal cavity, chloral hydrate produces marked irritation of the secreting cells of the kidneys. Even after the first injection it causes visible granular degeneration of the epithelium of the convoluted tubules, while after prolonged administration the epithelium of all renal tubules, undergoes degeneration, with the single exception of that of the straight tubes.

In more severe cases it produces swelling of all the renal epithelium, with other symptoms of acute parenchymatous nephritis, although the Malpighian glomeruli are never affected, nor is there ever any implication of the interstitial connective tissue.

The intensity of this destructive process depends partly upon the duration of the poisoning, partly also upon the individual's susceptibility. If the remedy is introduced through the stomach, it may likewise produce degenerative changes, but not to as marked a degree or as rapidly as when it is injected into the peritoneal cavity. The lesions thus described of the renal tissue are stated by the author to disappear after suspension of the use of this drug. Nevertheless, the author states that in none of the cases in which the post-mortem examination proved this condition to be present, did he ever during life succeed in detecting any albuminuria, a fact which will, perhaps, explain the great scarcity of clinical observation pointing to the danger of chloral from its action on the kidneys. The author's observations, however, show that the kidneys are liable to marked disorganization from the action of chloral, and should serve to indicate the necessity for great caution in the employment of chloral in cases where the kidneys are already affected.—*Therapeutic Gazette.*

THE RACE FOR NEW DRUGS.—There appeared in *The Medical News* of November 7th an able and vigorous editorial article based upon the report of a case of poisoning by "antikamnia," calling attention to the dangers of prescribing pharmaceutical products the composition of which is unknown, and roundly denouncing manufacturers for foisting such goods upon the profession.

But the substance named is only one of hundreds of so-called new remedies, the manufacturers from the sale of which, with the aid of the medical profession, are waxing rich. These preparations effusively lauded to physicians by their introducers, and thrust upon our notice in every conceivable way—and it is rarely the case that the extravagant and often ridiculous claims made for them are not fortified by apparently reputable medical authority. This appears to be, in fact, a *sine qua non* to "success" in the new venture.

For the real cause of this evil, however, it seems to me that we need not go so far from home as to the chemist or to the pharmacologist. It is but incidental to a far greater evil that pervades the

medical profession and for which physicians themselves are responsible. I refer to the craze for therapeutic novelties—the mad rush for new remedies that has been observable for the last few years.

It is a deplorable fact that manufacturers are not more eager to sell their new, fancifully named products than physicians are to prescribe them. Scientific conservatism has been flung to the winds and a spirit of reckless experimentation seems to have taken possession of the profession. The pharmacologists and chemists are merely profiting by the occasion. The credulity and the recklessness of physicians means dollars and cents to the manufacturers. As between the latter and the physicians who prescribe their nostrums and by whose encouragement and patronage they thrive, the manufacturers are the less culpable.

It is indeed "time to speak plainly and act courageously." It is time for such leaders in true medical progress as *The News* to call a halt upon the present reckless, indiscriminate, and dangerous practice of prescribing new and untried pharmaceutical products. It is not because of this tendency, but in spite of it, the real advance in modern therapeutics has been made. No "new remedy" should find a place in the armamentarium of the private practitioner until its physiological and therapeutic actions have been carefully studied and its value proved by observers of unquestioned competency.—George Emerson Shuey, M.D., in *Med. News*.

PISTOL SHOT WOUND OF THE BRAIN.—Joseph Ranshoff, M.D.—*The Cincinnati Lancet Clinic*. A young man, *æt.* 20, fired a twenty-two caliber ball into his left temple, and fell to the ground pale and excited, but conscious. The wound, two inches behind the external angular process and an inch above the zygoma, was filled with a blood clot; no oozing; pulse and respiration normal; pupils active and equal. Paraphasia was present. An antiseptic dressing was applied for the night, but by morning his condition had changed for the worse, delirium setting in, pulse hard and frequent; temperature 101°.

An exploratory trephining was made by enlarging the entrance of the wound and exposing the irregular opening in the skull which showed the edges blackened, and roughened. With a half-inch trephine and rongeur the opening was increased to nearly an inch, freely exposing the small, blackened aperture in the dura. The head now being placed on the right side, and an examination being made with an acorn-tipped hollow wire bougie, it revealed the fact that the bullet had followed an inward course, deviating downward and slightly forward. There were two spiculæ of bone at the depth of an inch and a half, which were removed. A bony surface arrested the

course of the probe at the depth of two inches, but nothing was seen or felt of the ball. But slight hæmorrhage was met with which was easily controlled. A drainage tube was carried into the depth of the sinus, and the external wound closed by sutures and loosely packed with sterilized gauze about the tube.

The first dressing with drainage tube was not removed for eight days, and after second dressing the wound healed entirely. The delirium did not return at any time, temperature was not above normal, and the process of wound repair was without a flaw. Five months afterward the patient was in perfect health and resumed work.

TEA-TIPPLING.—In an editorial on tea-tipping the *Lancet* says: We desire to assist in impressing upon women especially the fact that the immoderate use of their favorite beverage is fraught with considerable danger to health, and that this is especially true of those who lead for the most part an in-door life. Too often, unfortunately, conviction that the habit is injurious comes only after the break down, and the harm which has been done takes a good deal of undoing. It is idle to argue that Australian shepherds or half-savage Tartars drink tea in immoderate quantities, and are none the worse for it. Their mode of life enables them to do many things—we shall not say with impunity—which town dwellers cannot do, and we are convinced that no one living for the most part an in-door city life can continue to indulge freely in tea five or six times a day without suffering for it in the end. Whether or not "envy, malice, and all uncharitableness" are, as some assert, productive of indigestion, there is no doubt that excessive tea-drinking is, and for our own part we are inclined to think that indigestion is at least as often the parent as it is the child of the vices which have been mentioned.—*Med. Rec.*

DRINK AND THE DEATH RATE.—The relation of drink consumption to the death rate formed the subject of a communication recently made to the Manchester Medico-Ethical Association by Mr. Meacham, district medical officer. The reporter recorded it as his experience of thirty years of work among all classes of the people, that a very large percentage of disease is directly attributable to the influence of alcohol. In congested parts of the city this was especially the case, and he urged on the association the duty that rested on it, of doing all that lay in its power to aid the corporation of Manchester in the efforts that were being made to promote temperance principles among the masses. Mr. Meacham attributed 21 per cent of pauperism met with to the hereditary influences resulting from drink excesses. He had compared the children of drunkards with those of temperate parents and found that the latter possessed vast

advantages over the former in respect to healthfulness and freedom from diseases.—*Med. Press and Circular*.

BIRTH OF A VIABLE CHILD AT SIX MONTHS AND A HALF.—The woman was thirty-three years of age, had been married eleven years, and had had four children at term and one miscarriage. She had been under the speaker's care for chronic pelvic peritonitis, which fact had given him opportunities for observation in the case that he might not otherwise have had. On July 5, 1890, she menstruated as usual. On August 6th there was a scanty flow for three days. During the third week in August, changes were noticed in the uterus characteristic of the earlier weeks of pregnancy. The woman stated that conception must have occurred on July 13th, denying its possibility before that date. On January 4, 1891, while she was working a sewing machine, there was a sudden and profuse hemorrhage. All attempts to prevent labor were futile, and on February 3rd she was delivered of a small male child weighing two pounds and two ounces. The child cried at once, and, wrapping it up warmly, the speaker waited for some five minutes till pulsation in the cord had ceased before separating the child from its mother. The placenta gave some trouble, and there was found attached to it an independent lobule. The bones of the child's skull were soft and overlapping. The testes had not descended, and the finger nails were only just showing. The infant was wrapped in wool and put in a basket, which was placed near a fire kept continually burning. At first the child was fed with milk and water from a spoon every two hours, and subsequently from the breast. It has since continued to thrive in every respect. The date at which the child was born and the general condition of its development would indicate the period of gestation at six months and a half.—Dr. H. Collyer in *N. Y. Med. Jour.*

DENTITION AND INFANTILE DISEASE.—Brothers (*Archives of Pediatrics*), maintains that dentition is rarely or never a cause of death. He believes that dentition may be precocious or retarded in otherwise healthy children or in families. In the majority of healthy, breast-fed infants the eruption of the first teeth begins at six and a half months and is completed at thirty months. In children brought up on a mixed or artificial diet, primary as well as secondary dentition is distinctly retarded. Congenital disease—tuberculosis, syphilis, endocarditis—seems to retard dentition. Rhachitis has a pronounced retarding influence upon dentition. Scrofulosis seems to accelerate the eruption of the first teeth, but does not affect subsequent dentition. In cases of defective cerebral development, as in idiocy, the whole pro-

cess of dentition is retarded. Chronic disease retards the eruption of the first teeth, but does not influence subsequent dentition. In marantic children, primary dentition is precocious, but secondary dentition is delayed. Epileptics seem to have their first teeth early.—*Med. Prog.*

COCAINE IN GASTRALGIA.—Dr. G. W. Steeves (*Lancet*) says he believes cocaine to have special efficacy in certain cases of gastralgia. In two instances, one of which was accompanied by intense gastric irritability (all food and liquid being immediately vomited), the exhibition of the drug was followed by almost immediate relief. Other treatment by morphine, belladonna, etc., had been previously tried, with no beneficial results. One case was that of a hysterical young lady, who, in addition to excessive gastric pain and epigastric tenderness, suffered from a general condition of hyperæsthesia. This patient had been under observation for ten days with no improvement whatever, but after the cocaine had been administered for twenty-four hours the pain was subdued, and remained so. She has not had an attack since, although previously to this similar seizures had been periodical, especially on the approach of menstruation. The hydrochlorate of cocaine was given internally in doses of $\frac{1}{4}$ grain every four hours; or more frequently if the gastric pain was excessive.

A MEDICAL man, practising not far from the Middlesex Hospital, who finds his practice much injured by the competition of special hospitals, writes:

"Can such an institution as the Hospital for Diseases of the Heart be necessary? So many hospitals for paralysis cannot be necessary. The Hospital for Paralysis, in Queen Square, might remain, as it is a good clinique, but let it be safeguarded and not give indiscriminate advice, and, say, attach it to the general hospitals as a branch or department where certain students, according to advancement, would be compelled to attend the practice. Again, can a special hospital for diseases of the hip be necessary? Provision ought to be made in general hospitals for these cases, although they may be long or chronic cases." The writer of the above should join the General Practitioners' Alliance, which has been formed to deal with the evils he complains of.—*Hosp. Gaz.*

TOPICAL APPLICATION FOR DIPHTHERIA.—Dr. Zimmerman, *Med. News*, suggests the following as having been signally successful in his hands:

R.—Acid sulphurosi fʒss.
Liquor potass gtt xl.
Aque calcis ad fʒiv.

Mix, filter; keep well corked, in a cool place. To be applied topically to the throat by means of a sponge, probably every hour or two.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical
Science, Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice.
Address, DR. J. L. DAVISON, 12 Charles St., Toronto.

Advertisements inserted on the most liberal terms. All Letters and Remittances to be addressed to DR. C. SHEARD, 320 Jarvis St., Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER 23 Rue Richer, Paris.

TORONTO, FEBRUARY, 1892.

The LANCET has the Largest Circulation of any
Medical Journal in Canada.

MEDICAL EDUCATION IN ONTARIO.

It has been Ontario's wise policy for many years to give public aid very liberally for purposes of general education, from the Public School up to the University—and even to Agricultural Colleges, and to the teaching of such branches of science as form part of a general education. But for forty years in Ontario the principle has been asserted and carried out, that it is no part of the duty of the State to use public funds of any kind, in educating students for special professions, such as medicine or law, any more than for any other calling by which people earn their living. For this reason, the trifling equal grants given to each of our medical colleges for some years, by the late Attorney-General, J. Sandfield Macdonald, were entirely withdrawn, and have never been restored. Long ago, the medical faculty of the University of Toronto, which was maintained at the public expense, and was the only medical faculty in the province so maintained, was discontinued solely on this ground, only two members of the old parliament of Canada voting for its retention. And since the recent restoration of a state-subsidized medical faculty to the same institution,—it has been proved to a demonstration, just as it was in former days, "that private enterprise without any public aid whatever, is abundantly able to supply as many thoroughly educated young doctors and lawyers as the province requires—besides furnishing in the case of the doctors, a very considerable

number, who from preference go abroad to exercise their calling." It was also long ago proved, and it is proved no less decisively to-day, that the quality of the professional men educated by a medical faculty maintained in part at the public expense, is no better, nor do they take any higher standing than others, towards whose education not one fraction of public money has been contributed. To-day, and for years past, the standing of the candidates from our various medical colleges, at the examinations of the Examining Boards in Great Britain, and at the examinations of the Medical Council, which all who intend residing in Ontario have to take, proclaims this clearly, over the whole land. Can there be any more convincing evidence than this, of the extreme impolicy, as well as the gross injustice, of subsidizing one out of the six medical teaching faculties, which, including the colleges for women, exist in Ontario? Our province is inhabited by sensible people, and has a sensible, level-headed medical profession who can see and judge of such matters for themselves, and if the future is to be judged of by the past, the injustice of which we loudly complain, will be remedied before long.

In 1887, as soon as the medical faculty was restored, but not before, the new Biological buildings in the Park, were hurried on to completion. On these buildings with their equipment, many thousands of dollars of public money were spent. During their erection and since their completion, it was given out, that they were intended for the sole use of the Arts Department, which the public rightly regard as the essential part, the back bone of the university. If this department required accommodation for its science teaching, it is right that it should have all it needs, without stint, but every one knows that the provision made, far exceeds any possible needs of the not very many Arts students who take the science course, and, as a matter of fact, from the moment these buildings were opened till now, they have been, and they continue to be, used largely for medical teaching purposes—indeed they were so advertised in the official calendar—and as such they are on every occasion being exhibited to medical students, to visitors, and to the public.

On the 1st of October, 1890, at a meeting in connection with the opening of the University of Toronto Medical College for session 1890-91,

which was held in these new biological buildings, Sir Daniel Wilson, in his address, referred to their cost and to the purposes for which the buildings had been erected and equipped so clearly as to leave nothing to be desired on that point. The *Toronto World*, of Oct. 2nd, 1890, reports Sir Daniel Wilson as saying that "Toronto University had spent some \$130,000 on these magnificent buildings to give medical students the best equipped school in Europe or America." We were present on the occasion, and well remember the boasting style of this address, and his mention of a very large amount of money as having been laid out in the way stated. The speaker must surely have felt that the spending of all this public money in such a way was unjust to the general public and to all Ontario's other incorporated and entirely self-sustaining medical colleges, which have built and equipped at their own cost, and very thoroughly too, all the buildings they require, and with such good results that they have gone on steadily prospering in spite of this lavish use of public funds to crush or cripple them. Does the Ontario public, or the medical profession in our province, wish to have public, that is, their own money, used in this unfair way? Happily the medical colleges treated with such gross injustice have not suffered from it—its effect has been to turn the tide of public and professional sympathy in their favor more largely than ever before in their history. Their halls are well filled with young men who, with their friends all over the country, are determined to have the injustice they complain of brought to an end as soon as possible. In view of the facts stated, and of others yet to be referred to, is it not extraordinary that when the restoration of the University Medical Faculty was first mooted, it was distinctly and repeatedly stated, inside and outside the Legislature, by responsible parties in very high position, that it would be entirely self-sustaining and would not cost the country or the University a single dollar?

On the occasion of the disastrous fire of February, 1890, the Legislature at once, and without a dissentient vote, voiced the feeling of the country by ordering the sum of \$160,000 to be given to the University to aid in restoring the burned buildings. At the same time, by the friends of the University all over the country, many liberal donations were given spontaneously. But at this

very time, or almost immediately afterwards, another extensive and very costly building was contracted for, and pushed as rapidly forward as possible.

This is known, since the issue of the Hon. Ed. Blake's recent University Finance Committee's Report, Nov. 1891, as building No. II., in contradistinction to the main Biological Building, which is styled Building No. I. It adjoins the main Biological Department. Completed only a few months ago, this building was manifestly intended for medical teaching purposes, although during its construction this was a carefully-kept secret. It is, to all intents and purposes, a medical school building, including dissecting rooms above, vat rooms for preserving anatomical material below, with class rooms for other medical work between. It may, perhaps, be used for a certain amount of arts teaching; but the official calendar for Session 1891-92 announces that all the teaching of the University medical students of the first and second years will be done in it. This very costly building was also paid for entirely out of the funds of the University, that is, with public money.

In the Finance Committee's Report, above referred to, the cost of Building No. II, is placed at or upwards of \$71,000. It is said that the outlay on buildings and equipments, largely for medical teaching purposes, is one way or another, not far below \$145,000. It is admitted that the Government, as such, knew nothing of the purposes for which this last building was intended, till some months ago, when it was examined after its completion. Most unquestionably the Legislature of Ontario, which voted \$160,000 to aid in repairing the damage done by the fire, had no idea that the most of this sum would be spent in a way never for a moment intended, viz., on dissecting rooms, vat rooms, planned for the study of human anatomy, and for other class rooms, chiefly for the medical students attending this one college, while our other five medical colleges provide and equip every building they require; wholly at their own cost, and impart as good a medical education as is given in any part of the empire, without costing the province, or any one of our public funds, so much as one cent.

Why should our Ontario Government have permitted these great and, to the other medical

colleges, most unjust outlays; most unjust, too, to the Arts Department of the University, which needs all the money it can get from every quarter, and even more, to meet its large and ever increasing necessities. The public, the other medical colleges, and the Legislature of Ontario, ever since the session of 1887, have been solemnly and repeatedly assured by the highest educational authority, speaking on behalf of the Government, that the carrying out of the Medical Faculty restoration scheme would not involve the spending of a dollar of University or any other public money.

Yet we find that by far the greater part of the generous legislative gift of \$160,000 has been lavishly spent in a way which was never authorized, nor even dreamt of by the House, which voted the money, or by the country to which the money so voted belonged. The precise outlay cannot be got at, but the character of the buildings and the uses to which they are put, and the fact that the public paid for them, cannot be questioned.

As a further necessary result of the present unfair policy, the self-sustaining colleges find the Provincial University, not as they might naturally expect in an institution which, as part of the public, they help to maintain, a friendly co-worker with each of them, but an active competitor for every student, competing unfairly, too, on account of the Provincial institution being so largely subsidized out of the public funds. Only last spring a further very bold movement was made public, when an influential committee of the Senate was appointed to ask the Government to sanction the endowment, at the public cost, of three chairs in the restored medical faculty. This came to nothing, for it was at once and very strongly protested against. Several influential members of the Senate, too, were known to disapprove of the suggestion, yet only the other day, certain speakers at a University public gathering referred to further action on this very matter, as being "merely postponed" on account of the losses caused by the late fire, thus plainly foreshadowing their intention of again, in due time, pressing this preposterous claim on the Government.

In the case of these three chairs sought to be endowed, at the expense of the public in this already largely subsidized University medical college, it is right that the Government and the

public should know, that in the self-sustaining colleges, each of them is filled by a professor, who, in every instance, is fully competent to teach the subject committed to his care with thoroughness. Besides this, all expenses connected with these chairs, including the payment of the professors, are, as they should be, borne by the fees of the students who attend the respective classes.

Had the Government, openly and above board, avowed its intention to swamp or cripple our independent medical colleges, which have done, and are doing, such excellent work, the course which has been pursued is exactly what might have been expected. Indeed nothing in the direction of injuring them, which could have been at all safely attempted, has been left undone. But, happily, the effect produced in the country by this strange policy, has been one which had apparently not been anticipated. A very strong feeling of sympathy has everywhere sprung up in favor of the independent colleges, to which not merely scant justice, but the grossest of injustice has been done by the Government which chartered them, and from which they naturally expected at least "a fair field for all, with special favors for none." This sympathy has greatly sustained and encouraged them, for it is manifestly based on a very large share of the confidence of the public and of the profession. These institutions continue to work most successfully with large classes, and intend to work even harder in future. To the Government and to the Legislature of the province we continue to look for redress, and we believe our expectations will not be disappointed for any long time, for the profession and the public largely and very strongly hold views on this subject identical with those expressed in this article.

The term for which the medical faculty appointments in the University were made in 1887 (five years) will shortly expire. And it is perfectly possible, exceedingly desirable, and well within the power of the Government, to reconstruct this faculty in some way which shall be quite fair instead of grossly unfair to all the other medical colleges of the province. And as a foundation principle let it be clearly laid down that every teaching medical body in Ontario shall provide its own buildings and equipments free of even a dollar's cost to any public fund. The law faculty of the University, as it at present exists, would be an

excellent model on which to reconstruct the medical faculty. It costs nothing, either for buildings, or equipment. Its professors are not salaried—and what teaching they do is of so general a character as to be interesting to any one who wishes to be considered well educated.

The law faculty does not compete at all with the self-sustaining law school connected with the Law Society. And it is a question that presses for an answer why Government should ever have consented to make the medical faculty the very opposite of all this—very costly to the public and to the University—and actively competing with the excellent medical colleges which admittedly teach medicine quite as well and cost the public nothing. And it would be very easy to use the buildings recently erected at such great public cost to aid in carrying on the University Arts and Science Departments with full success.

The teachers of the various branches of the Science Department being entirely paid out of the general public funds of the University, which are public funds, it is *most objectionable* that they should form a part, or be advertised as forming a part, of any *one* medical faculty whether that of the University itself or any other. The adoption of this principle is called for by the Provincial University. The mere charging a sum as rent against the medical faculty of the University, as is now said to be proposed, or arranged for, fractional as it is, in proportion to the great cost of the buildings, will not meet the case. Many of the best friends of the University of Toronto are of the opinion—and their number is fast increasing—that were she to apply her entire energies and resources to develop her Arts and Science Departments, she would find *ample, and to the country, most profitable work* for any number of coming years, and work regarding which no complaints of injustice would be made. But in a province like ours, where there is a sufficient number of excellent medical colleges in operation and all of them have been so long self-sustaining, there should be no subsidizing now, of any one them, directly or indirectly.

If there must be a medical faculty in Toronto University, it should certainly be as purely and squarely self-supporting in every respect, as all the other medical colleges are, and in that case, without interfering with the autonomy, or the legal rights of any of these colleges, our Provincial Uni-

versity might ally herself by special affiliation and be friendly with them all, instead of occupying as now ^{the} the undignified and unprovincial position of being a keen and a most unfair, because a subsidized, competitor with them for every student—and this, notwithstanding the fact, that some of these colleges have been for many years affiliated with her. A just and liberal policy of this kind would attract many students for graduation in medicine from all the teaching colleges, who are now, as is their undoubted right, being educated in the institutions of their choice, and who under present circumstances would not think of such a thing. But it is the Government which can and should, as speedily as may be, bring about such changes as will forever put an end to unfairness, and establish what is just and right on a firm basis—a basis which shall be equally just to each of our medical colleges, of which Ontario and her Government have good reason to be proud.

There is still another and a very glaring abuse, long since pointed out, but still entirely uncorrected. The overwhelming evidence of figures proves that State paid University professors are, and have been, ever since 1887, earning a large yearly bonus for the medical faculty of the University, which bonus, the fees of every medical student, wherever he may come from, goes to swell, while the respective medical faculties of all the other medical colleges get nothing but what they themselves earn. This abuse, is as follows: In the University of Toronto, under a special University Statute, approved of by the Government before it could come in force, all fees paid by medical students go into the funds of the "medical faculty," and not into the "General Funds" of the University. Since 1887 Physiology, General Chemistry, Practical Chemistry, Biology, including Botany and Zoology, have been taught to the medical students of the University of Toronto by professors and other teachers, whose salaries are wholly paid out of the "General Funds" of the University.

These medical students pay very much the same fees for this teaching, as are charged in all other medical colleges in Ontario, in which colleges however, every teacher is paid solely out of the fees he individually earns.

The fees paid by every 1st year's student for the branches above named amount to \$34, and the

amount paid by each 2nd year's student for this teaching, done wholly by State paid teaching, is \$37.

Suppose there are 60 students in each of these year's, and this is a fair average; 60×34 will give \$2040, received in fees from 1st year's men, 60×37 will give \$2220, received from 2nd year's men, making a grand bonus of \$4260 from the men of these two years, which goes into the "Medical Fund." The fees, therefore, which University of Toronto medical students pay for the branches named, do not go, as they should, into the general funds of the University, to help to pay the salaries of those who earn them, but under the statute above referred, are paid into the "Medical Faculty Fund," which fund is distributed (less expenses) amongst the teachers of purely medical subjects. Thus certain University of Toronto Arts professors, earn this large amount of medical students' fees, which goes, not into the general fund of the University—the needs of which are great, but to be distributed in a proportion fixed by University Statute, to various members of the medical faculty who do not earn any part of it, and who do not teach the subjects for which it is paid. For the statute, and even the exact proportion given to each teacher, and the list of names of those who share these fees, see Ontario Sessional Papers, 1887, No. 52, page 110.

This volume is in the library of the legislature and may be consulted by any one who wishes to do so. In the list of names in this statute, those of the State paid gentlemen who earn the fees referred to are not given, but the names of the medical teachers who receive their respective shares of this money, which they do not earn, will be found. Till now, Feb., 1892, this glaring abuse, long since so clearly proved, that no denial of its existence has come or can come from any quarter, remains unrectified. It is a great wrong—first to the Arts Department of the University itself, which should have this money earned by University paid teachers placed to her credit—but it is a far greater wrong to our other five chartered medical colleges, which ask no public aid and receive none.

The teaching medical faculty was restored to the University under the impression that the interests of the provincial institution would be thereby promoted, and those prominent university

officials who favored its restoration did so on this ground. But we submit as a principle that invariably holds good, that any change of this kind, made in such a way as to be unsound in principle on the very face of it, and most unfair to every other medical college in the province, could not, in the nature of things, prove ultimately beneficial, or indeed otherwise than most injurious to any institution whose friends sought, in this mistaken way, to do it service. The press is speaking out very clearly on this subject, and there is no time to lose in setting matters right. A Hamilton paper of recent date says: "This (*i. e.* the present arrangement) is not only unfair to the medical schools which receive no public assistance, but it is unfair to the public who pay the taxes." The *Toronto Week* says: "That the Legislature of Ontario either intended or would consent that any portion of the public funds should be used for the purpose of aiding in the work of medical education proper, thus bringing the Provincial University into competition with the self-supporting colleges which are doing the same work, and doing it well, we cannot for a moment suppose." A late Amherstburg paper says: "A liberal education is provided for all in Ontario, but it now looks as if our doctors are to be educated by the State, and if doctors, why not business men, telegraph operators, lawyers, mechanics, artisans and laborers?" A recent Kingston paper says: "It is neither fair to the self-supporting schools nor to the professions of law, civil engineering, etc., that Toronto Medical School should be supported either in whole or part by Government funds."

MEDICAL MEN AS DISPENSERS.

The question as to whether physicians shall dispense their own medicines or not is now agitating the medical mind in the United States, and many are the arguments *pro* and *con*. One medical society (Cincinnati) goes so far as to attempt to make it obligatory for all its members to always prescribe, never to dispense their medicines. On the other hand, many eminent men express it as their opinion that in this day of scientific pharmaceutical preparations, the physician should leave the day's supplies of triturates with the patient, thus preventing the unsightly accumulation of half-

empty bottles that cover the mantles and stands of nearly every sick chamber, at the same time saving the patient the extra fee for drugs, while the increased number of calls rendered necessary would be better for the doctor from a financial standpoint. It is claimed that much of the success of homœopathy, which is making such headway in the United States, is due to the fact that the drugs are given by the physician to patients. One of the arguments in favor of the tablet triturates is their cheapness, and as a general thing their scientific exactness of dose. On the other hand there is one objection which may be urged against the triturate or any solid drug, and that is the fact the absorption is not so certain or speedy when the drug is given in the solid as in liquid state.

It is certain that salicylic acid and quinine are more liable to have the desired therapeutic action if given in solution, there not being the same liability of giving rise to gastric irritability when these drugs have to be given for any length of time. Opium, too, will sometimes disappoint if given in pill or tablet form. At the same time, the objection above can, in a great measure, be obviated by pulverizing the tablet and mixing it with some suitable menstruum.

Another more serious objection has been raised by the *Therapeutic Gazette*: "Already the competition between manufacturing houses is great. The physician would have no interest in buying his supplies as cheaply as possible, and there might be a temptation for the pharmacist, to fraud in the quality of his drugs and an incentive to short weight, hence the element of unreliability is introduced."

But this objection can also be applied to some retail druggists. Changes have been known to occur in the putting up of prescriptions, when, for instance, strychnine has been substituted for quinine (because cheaper), and an important ingredient of the prescription has been left out because the chemist did not happen to have it in stock.

In Canada, we are happy to say that the druggists are of a higher moral standing than in the United States; and it would not be more than right to state that, as a rule, they are conscientious, hardworking men and thoroughly reliable.

THE NEW DIPHTHERIA HOSPITAL.

One of the local newspapers recently drew attention to the fact that the new diphtheria hospital, instituted by the Board of Health, for the isolation of patients suffering from that terrible scourge, was being managed in a very peculiar manner, having only one nurse to about nineteen patients, who are nearly all in one ward; also that the nurse had to spray the children's throats, holding in one hand a lamp, and endeavoring with the other to overcome the patient's struggles and use the solution for spraying the throat at the same time—a thing it would take all her skill to manage. If these reports be true, it is no wonder that parents object to the law stepping in, taking the children suffering from this disease, and placing them in such a comfortless barracks as the account in the *World* would lead people to believe the hospital to be. Nor is this all. Each patient should be isolated, for we are well aware how exceedingly difficult it frequently becomes to make a correct diagnosis between tonsillitis—especially the follicular form—and diphtheria, for in the latter disease the membrane is sometimes wanting, as Morell McKenzie has pointed out, and most practitioners would prefer to call quinsy diphtheria, and err on the safe side. This would be all right if each patient was kept separate from the others, but, let us suppose a case of tonsillitis is sent to this hospital, placed in a ward with others suffering from genuine diphtheria, and what do we find? That the comparatively mild affection has graded upon it the more malignant disease, with death, perhaps, as the outcome. The fault lies in the penny wise, pound foolish policy of the City Council, who, at the present moment, are suffering from an acute attack of economical mania, and seem to endeavor in every way to hamper the laudable efforts of Health Officer Allen to give us a clean bill of health.

BELL TELEPHONE CO.

We hear a great many complaints from medical men regarding the action of the Bell Telephone Co., in charging \$40 per annum for the use of their instruments, while \$25 is the rate for private houses, where, as a rule, the telephone is used as

frequently, if not more so, than in the physician's office. The Company last year made a sort of indefinite promise to lower the rates, but have not done so, hence the complaints we hear on every hand. In our opinion \$25 would be quite sufficient remuneration for the present service, which, as a rule, is nearly useless after dark, owing to the current from the electric light system, causing such a buzzing and roaring that little else can be heard. Of course the Bell Telephone Co. being a monopoly has the advantage of being able to dictate their own terms. But if the medical men of the province drop a hint to their local members of the privileges now enjoyed by the Company might be curtailed, or, if that was impossible, a new and rival corporation might be successful in their efforts to obtain Legislative recognition. It would not be a bad idea to have a meeting of the medical men convened to discuss the matter during the coming summer.

PROPHYLAXIS OF INHERITED INEBRIETY.—At the quarterly meeting of the Society for the Study of Inebriety, on January 5th, Dr. Charles Hare presiding, a paper was read by Dr. James Stewart (*Br. Med. Jour.*), who said they could not too often, as scientific men, protest against the use of the words drunkenness and inebriety as if they were controvertible terms. M. Trélat had put the difference very clearly: "Drunkards are people who drink when they find any opportunity of drinking; dipsomaniacs are diseased persons who get drunk whenever their attack seizes them." The conclusions arrived at were summarized as follows: 1. Drunkenness is a vice, inebriety a disease. 2. The disease of inebriety once established may be transmitted to the offspring, either in the form of the alcoholic diathesis, epilepsy, chorea, insanity, or even tendency to crime. 3. The child of an inebriate, born after the functional or structural lesion has been established, is sure to inherit some nervous diathesis. 4. The only security against this diathesis developing as inebriety is by lifelong total abstinence on the part of the child. 5. Even the adoption of this precaution will not absolutely make certain that there will be no transmission of the cachexia by the child to his or her own offspring. 6. To prevent the development of the alcoholic neurosis in other directions—

such as epilepsy—sudden excitement of the emotions and sensibilities (such as might be produced by corporal punishment at the hands of strangers) should in all cases be guarded against. 7. In the prophylaxis of inebriety the principle to be acted on with regard to children's training is that, if the good be accentuated, the evil is attenuated. 8. The marriage of the child or even grandchild of an inebriate to a first cousin should be absolutely interdicted. A brief discussion ensued.

SALTS OF STRONTIUM.—Dujardin-Beaumetz (*Sem. Méd.—Br. Med. Jour.*) makes some further statements as to the clinical uses of salts of strontium. The only salt of which he had had any experience was the lactate. This he had employed in a number of cases of Bright's disease, with albuminuria; under its influence he had the satisfaction of seeing the albumen diminish very considerably, in some cases being reduced to one-half of that previously excreted. He attributed this favorable action rather to the very beneficial action of the strontium salts on digestion than to their direct action on the kidneys. At the same time he pointed out that the greater or less quantity of albumen passed was of less importance in the prognosis of the disease than the proportion of toxins retained in the organism, which the renal filter either retains or allows to pass into the urine. He recommended that a milk and vegetable diet be employed in combination with the drug, which he gave in doses of ʒjss. per diem.

PUNCTURE IN CHRONIC HYDROCEPHALUS.—Karnitzky (*Arch. für Ped., Br. Med. Jour.*) reports five cases of chronic hydrocephalus treated by puncture. In none of the cases did any complication follow the operation, which was performed with aseptic instruments. In two cases the child died; in one the head was tapped twice, in the other five times; in the latter, death was due to diarrhoea, and considerable improvement followed the first tapping. In another case, tapped five times, the child was growing rapidly worse when last seen; one case was only under observation five days; in the fifth case—a female child, 11 months old, with a very large head, with extremely thin bones—six punctures were made during the course of a month; the circumference

of the head was reduced from 70 to 62 centimetres, and when at the end of this time the child ceased to be brought for treatment, it appeared to be doing well.

LYMAN BROS. TABLETS.—We desire to call the attention of the medical profession to the tablets manufactured by Messr. Lyman Bros., Front St. E., Toronto. The quinine tablets are especially to be commended, filling, as they do, a long felt want, in that quinine can be administered in a tasteless form and not in capsule. Many patients are not able to swallow capsules, and object to quinine in an acid vehicle. These tablets disintegrate in from one to two minutes in water, and when given during such period are wholly tasteless; they can also be placed upon the tongue and allowed to remain for a minute until they soften, and their deglutition aided by a draught of water. We have tried them and have been so favorably impressed with their use as to recommend them where other modes of administering quinine presents any difficulties.

The same firm are producing other tablets which are giving very great satisfaction, notably that of *cannabis indica*, which from the purity of the drug employed has given great satisfaction.

ECZEMA.—Hollopeter has used with great success (*Times and Reg.*) the following:

R.—Ac. salicylic. gr. xx.
Zinci. oleat ʒij.
Cocaine gr. v.
Pulv. amyl, q. s. ʒij.—M.

Sig.—Use as powder, externally.

The salicylic acid prevents fermentative changes in the skin; oleate of zinc adheres very closely to the skin, and protects it; the cocaine may be put in or left out, conditionally as to whether there is pain or not.

If, on the second visit, there is little pain, and the scales are drying up, the cocaine may be discarded; later, the zinc may be left out, then the acid, so that finally only the starch is left. After this, alcohol may be used.

HOW TO ADMINISTER ETHER.—Dr. John A. Wyeth, of New York, repeated remarks (*Med. Rec.*) which he had made on a former occasion, in praise of the administration of ether by the Ormsby inhaler, whereby a maximum effect with a minimum amount was secured. He had operated half

an hour while using half an ounce of ether. By this inhaler the patient breathed the same air repeatedly, as it was confined in a rubber bag, and the anæsthesia was due doubtless largely to the carbonic acid gas inhaled. Where free air was constantly mixed with the ether, as by ordinary inhalers, the respiratory tract was chilled; much ether being used, internal organs, especially the kidneys, were liable to become affected.

PROLAPSUS ANI.—Dr. Adolphus, in *Ga. E. M. Jour.*, says: Prolapsus ani is often cured by hypodermic injections of strychnine. The canula is inserted about three-fourths of an inch from the anus and pushed straight down parallel with the rectum into the cellular tissue. About one-twelfth to one-sixteenth grain of strychnine is injected at each time; the operation may be repeated in severe cases every twenty-four hours, ordinarily every forty-eight. Seldom more than eight injections are needed to make a cure.

THE DISPENSARY ABUSE.—We (*Med. Record*), are pleased to see that the daily papers are agitating the question of dispensary abuses, and are taking sides with the younger practitioners. Numerous instances are related in which well-to-do patients crowd the waiting rooms, simply because they can get the best advice from experts for nothing, and without question. It is too bad, but it is true. Many of our hospitals do the same, and will be foremost in claiming numbers of so-called paupers treated when the hat goes around for the annual hospital collection, so near at hand.

TREATMENT OF HYPERIDROSIS.—In the *Revue Gén. de Clinique et de Thérap.*, the following prescription (*Med. News*) for sweating of the hands and feet is given. The application is to be made night and morning. The part is first washed with hot water and immediately afterward the following ointment is applied:

R.—Ichthyol 1 ounce.
Vaselin 1½ ounces.

PERSONAL.—We are pleased to note that Dr. R. T. Irvine (McGill '85) has been appointed by Governor Hill, as surgeon to the Sing Sing Hospital. His many Canadian friends will congratulate him.