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THE  
CANADIAN PRACTITIONER

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

EDITOR:

A. H. WRIGHT, B.A., M.D. Tor., M.R.C.S. England.

Business Management, - - The J. E. BRYANT COMPANY (Limited), 58 Bay Street.

TORONTO, JULY 16, 1892.

**Original Communications.**

HYSTERECTOMY WITH AND WITHOUT A PEDICLE: A CRITICAL REVIEW BASED ON CLINICAL HISTORIES.\*

BY DR. J. F. W. ROSS,

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For many years ovarian tumors were left inside of the abdomens of the poor unfortunates who carried them to their graves, after many tapings. To-day the weight of opinion is against such an apparently innocent procedure as tapping. Ovarian tumors that have never been tapped and that have never been the seat of inflammation can be readily removed in five or six minutes. No operation in surgery is simpler. Ovarian tumors that have been tapped or left so long that they have repeatedly become the seat of inflammation *cannot* be readily removed in five or six minutes. Such operations will tax the patience of the operator and the endurance of the patient. *Fibroid* tumors that grow, as they very frequently do, from a pedicle, or that fill up, as they frequently do, the fundus uteri, if they have not been left so long that they have repeatedly become the seat of inflammation or have not been tampered with (not by the trocar, but by the electrode), *may* be readily removed by an experienced operator, not, it is true, in five or six minutes, but at least within an hour. Fibroid tumors that have

been left to inflame after child-birth or miscarriage, after the use of electrodes introduced per vaginam or through the abdominal wall, fibroids that have become firmly adherent, can *only* be removed with *great* difficulty, and at times *cannot* be removed at all. Early operation for ovarian tumors is now the fashion, and rightly so. Ovarian tumors were said by the older authors to do but little harm, and patients were advised to have no graver operation than a tapping done—a temporary but grateful relief. It has for some time past been the habit of the profession to advise against the removal of fibroid tumors of the uterus, not because they could be tapped from time to time, but because they were supposed to be innocuous and to disappear at the menopause as readily as the stars do at the uprising of the sun. Instance upon instance has been quoted of patients suffering for years with fibroid tumors, suffering with pressure pains, with hemorrhages, with inflammatory attacks; going around with distended bellies carrying in their abdomens tumors that may suddenly take on some cellular change that will imperil the possessor as much as if she had a charge of some deadly explosive in her abdomen; and yet because such patients drag on a miserable existence, and because operation for the relief of such a condition is believed to be extremely hazardous, they are advised to let nature take her course. In no other instance is such a surgical blunder made. As the experience of any one becomes extended, he must be convinced that if operation for the removal of

\*Read before the Ontario Medical Association, June 2, 1892.

fibroid tumors of the uterus is improved so that the mortality in experienced hands is not excessive, operation is in most cases the correct procedure. I am now referring to cases in which removal of ovaries and tubes will be either too dangerous or of no avail. I believe that in dealing with large tumors that are growing rapidly or are so large that much handling will be required to remove the ovaries, and in dealing with the multinodular tumors where the uterus is filled with nodules and where hemorrhage is excessive, the operation that will give the most satisfactory results is that of hysterectomy. When a woman has an ovarian tumor we do not say to her, "There is great risk in removing your tumor;" but we say, "Your tumor must come out." We know well that it may perhaps be an intraligamentous cyst with terrific adhesions or a case of double ovarian tumor with equally dense adhesions, but do not say so to the patient. Our fibroid tumor may be removed much more readily than our ovarian tumor, and yet we advise operation in the one case and advise against it in the other. Having now satisfied ourselves that we cannot be mistaken in our diagnosis—for we never are mistaken if we never see inside of an abdomen—feeling that we know a pus tube when we feel it, that we know the difference between an ovarian tumor and a fibroid, that extra-uterine pregnancy cannot fool us, that we are quite familiar with the dermoid cysts, we now calmly advise tentative measures, and look about for remedies that are, at the best, but palliative. Our patients suffer on, and pass from hand to hand until at last they offer themselves on the surgical altar as a sacrifice. And how often does it prove a sacrifice! And why does it frequently prove a sacrifice? Because the surgeon is called to finish up what others have failed to complete; and only after the patient's health has been undermined, after desperate adhesions have formed, after suppuration or decomposition has begun in the tumor, and after the kidneys have become disorganized by pressure on the ureters.

I have seen good surgeons explore an abdomen, and, because they found their suspicions that the patient was the possessor of a fibroid verified, close the incision. I have seen surgeons handle large tumors in the endeavor to remove ovaries and tubes, and consume more time over

this operation than would have been consumed by a complete hysterectomy in the hands of any one familiar with the operation. And only into such hands should such cases fall. I never attempted to do a hysterectomy until I had assisted others to do a large number of them. And each case presents some new feature not presented by any of the others. There is no operation in the whole range of surgery from which the patient gains greater benefit, and there is no operation in which fatal blunders may be more easily made. The ureters are at times eccentric in the course they pursue; the bladder may be drawn far out of its normal position, reaching even to the umbilicus; the rectum may be adherent far up the tumor, and all of these must be protected from injury. A cool head is required. No operation requires more deliberation and knowledge of all its details, and yet withal rapidity of execution. The instruments used must be of the most approved patterns, and must always be ready to hand and aseptic. On the spur of the moment I have seen some terrible clamps put on these pedicles, veritable makeshifts, and of questionable cleanliness. When I have used the small serre-nœud, it goes at once to the silver platers before it is used again. Sponges are also a source of danger from the very urgency with which they are called for. Hemorrhage from adhesions is frequently alarming because we are unable to constrict the pedicle or to apply artery forceps to effectively control hemorrhage from such large vessels on the wall of a solid semi-elastic tumor. Hence sponge pressure is called for, and when the usual dozen sponges are all in use more are called for, and may not be aseptic as they should be; therefore a double supply of sponges should always be carried if there is the slightest shadow of a suspicion that what is begun as a probable ovariectomy may end in a hysterectomy.

Having now led up to the necessity for operation, let us look for a moment at the dangers of the old method by the clamp. After the clamp was abandoned in performing the operation of ovariectomy, the mortality diminished to such an extent that the reason of the diminution was easily apparent. Following in the footsteps of the pioneers of this operation, the abdominal surgeons attempted to remove fibroid tumors by dropping the pedicle, but

with signal defeat. Small pedicles submitted to such treatment, but the larger ones were not so tractable. They coozed, they bled, they sloughed, and refused to be so tenderly dealt with. A wire was then put about them and they were forced to remain outside of the abdomen. Many operators meet with remarkable success by this method, but the continued anxiety and worry of always looking, like Micawber, for something to turn up forced one of the most successful operators of this century to abandon operation and to again seek for palliative measures. The operation then received a blow from which it has not yet recovered. Other vaunted remedies were tried, as they were tried by our ancestors long years ago. Our ancestors failed, and we have failed to cure by these means. Enthusiasts stepped in, and the medical profession blindly followed. Anything to avoid the knife. An operator was avoided as if he had been a murderer, and he only received the crumbs that fell from the rich man's table. He was forced frequently to operate for glory or the love of humanity. It was an uphill fight. The fight was felt by many to be a fight against an unsurgical operation, an operation that left a dirty sloughing mass sitting on a dirt-aborring cavity. On this continent, Eastman reported his success by the no-pedicle method. I had myself written up such an ideal operation, but had not as yet performed it. The trend of European thought was in the same direction. Krug then took up the operation, and he, with Eastman and myself, felt convinced that the pedicle must go. At Richmond I brought the subject up for discussion before the Southern Surgical and Gynecological Society in November, 1891. Those who had done well and brilliantly with the clamp remained conservative, but were interestedly awaiting developments. What I said before the Michigan State Medical Society last month, when invited to describe the no-pedicle method, I may repeat here: "I will never do another abdominal hysterectomy with an extra-abdominal pedicle as long as I live if I can operate by this other method. I feel that this operation will be the one generally adopted before another five years are over. I can heartily recommend it." For the purpose of analysis, I select three cases done by each method, and will endeavor to

review the period of convalescence without prejudice.

*Case 1.* A fibro-myoma, the size of a man's head, with a pedicle formed by cornua of uterus after tying the broad ligament in which the tumor had developed with a chain suture on its outer side. The abdomen became distended shortly after the operation, but the flatus was expelled when the flatus tube was passed. This distension is evidently due to traction on the rectum by the pedicle. This distension disappeared on the fifth day. In this case a drainage tube was used above the point at which the pedicle was fixed, and was removed on the fourth day. Irritability of the bladder came on, and was troublesome. Clamp removed on the nineteenth day. In this case the temperature twice reached  $100\frac{2}{3}$ , and the highest pulse was 86. The pulse usually ran at about 65, and was unusually slow.

*Case 2.* A case of pregnancy and fibroid; fibroid weighing about thirty-five pounds. Pregnancy of five months' duration. Clamp and pins placed in lower angles of wound. Symptoms of distension set in very soon after the completion of the operation. What appeared to me to be obstructive vomiting set in, and enormous quantities of fluid were thrown up. It seemed as if the whole intestinal tract took part in the reverse peristalsis. An enormous number of enemata were administered, together with calomel, Seidlitz powders, magnesia sulph., cathartic pills, but without effect. I began to despair; but with all this vomiting the pulse ran at 66 to 90, clearly indicating that it was not due to peritonitis. The temperature at about  $99^{\circ}$ . To me the temperature is but a poor indicator, but the rapid pulse always makes me feel uneasy on two points, viz., hemorrhage or sepsis. Obstruction is generally at first accompanied by a moderately slow pulse and a slight, if any, rise of temperature. Peritonitis is always ushered in by a rapid pulse, let the temperature be either high or low. No drainage tube was used in this case. The pedicle sloughed above and below the clamp, and left an enormous hole to granulate from the bottom after the clamp came off on the twenty-first day. As the stump became putrid the temperature began to rise, and with it the pulse. Septic diarrhoea, a septic gastritis and enteritis and passage of undi-

gested food, set in. The temperature only reached 102°. During the septic period the patient slept badly. Eczema of the skin around the pedicle became troublesome in spite of the use of mildly alkaline and antiseptic unguents. Albumen appeared in the urine, together with fatty and granular casts on the twelfth day. The urine was reported as normal before operation. She suffered much abdominal pain even after the removal of the clamp and made a slow convalescence, having just barely escaped with her life. My anxiety was great, and continued until after the clamp was removed. After this period large gray sloughs came away from below the seat of constriction.

*Case 3.* A case of fibro-myoma about the size of a child's head. Pedicle fastened with pins and clamp in lower angle of wound. Drainage tube used above this for four days. In this case, the hemorrhage was troublesome from the stump. Though tanned thoroughly, the blood would ooze out of a pedicle almost as hard as bone on the surface. On two occasions I was hastily summoned to find the patient covered with blood-stained dressings. The nurse became alarmed and sent for me. I never encountered such an obstinate pedicle. If left untightened for an hour or two, it would bleed. Everything went well, with the above exception, until the sixth day, when the temperature rose to 103° and pulse to 100. Septic diarrhœa set in, accompanied by distension. The motions became greenish in color and offensive. The patient then went into what I call the typhoid condition of the second week. She lost rapidly in flesh and barely escaped with her life. Subsequent convalescence was very tedious. An abscess formed around the pedicle. After the clamp was removed on the seventeenth day, a large hole remained to granulate from the bottom, and sloughs came away from below the site of compression.

We now review three cases done by the no-pedicle method:

*Case 1.* Had been previously operated on by another surgeon, but had only one ovary removed. Tumor was very adherent. Had a mitral heart murmur and was not robust. The operation was a difficult one, but with Trendelenburg's position, vaginal staff, and a Wood's hernia needle, I soon managed to remove the uterus. There was

some hemorrhage from adhesions deep in pelvis, and iodoform gauze packing was required to control it. This was removed next day. The pulse and temperature rose at once to 100 and 102° respectively. Cough was troublesome from the irritation of ether. The greatest amount of disturbance of pulse and temperature occurred during the first few days subsequent to operation, and then everything went along smoothly. The patient made an easy convalescence, though affected with extreme nervousness for some time. She is not yet free from this nervous condition, due to the induced menopause. The wound healed by first intention. The stitches came away from the vagina, as did those tied on the broad ligaments.

*Case 2.* Operated on two years previously. Ovaries and tubes removed, but hemorrhage and pain continued. The operation was very difficult, and could not have been completed by any extra-peritoneal method. The patient was very anæmic before operation. The pulse was 100 when she left the table and 120 an hour later. The discharge of serum through the gauze packing in vagina seemed excessive. For the first few days the pulse ran high; I attributed this to the great anæmia and excessive discharge of serum. The pulse reached 148 on the second day, and remained above 130 for twenty-four hours, when it gradually came down. I put two nurses to nurse her, and ordered whiskey and milk every fifteen minutes by the mouth, treating the case by elevation of the foot of the bed as I would a case of severe hemorrhage. She made a rapid convalescence. The wound healed by first intention, and the stitches came away from the vagina without any difficulty.

*Case 3.* A case of five months' pregnancy and a fibro-myoma. Removed uterus and myoma. No pedicle left. Patient left the table with a pulse of 86. Pulse once reached 112. Highest temperature 105 $\frac{1}{3}$ . There was some distension that was easily controlled by purgatives. The wound healed readily throughout, and the patient made an easy convalescence. When leaving for Muskoka on May 19th last, she was sitting up and able to be out of bed, looking the picture of health. She was then four weeks past the time of operation. During my absence in Muskoka, symptoms of bowel obstruction set in and she died.<sup>85</sup> At the *post mortem* examination

a coil of intestine was found obstructed just under the incision. This death cannot be attributed to the operation. I never left a patient better in my life, and certainly was never more surprised than when I heard of her death.

I have now compared three cases in which pedicles were left, and three in which no pedicles were left. All of the cases survived the operation, even the last one, because I call that a successful operation. A surgeon cannot be held responsible for every complication that may arise when the patient is virtually over her operation and able to go about and out of his reach. I have brought down some of the tumors to give you a better idea of their size.

But a few days ago Case No. 3 of the first series came briskly into my office a happy, cheerful young woman of 35 years, the picture of health. Her enlarged abdomen and the high apron string that annoyed her so much have become things of the past, and she is now free from her unpleasant and inconvenient periodical excessive hemorrhages. This is but the history of one such case. If the patient survives operation the cure is complete, and the treatment of no growth or disease affecting the human being gives more satisfactory subsequent results than the complete removal of a uterus, the seat of troublesome and dangerous fibroids.

### SYRINGOMYELIA. \*

BY DR. D. C. MEYERS, TORONTO.

*Mr. President and Gentlemen:* The fact that syringomyelia has recently excited considerable discussion in other countries, and the hope that some microscopical sections of its pathology might be of interest to those engaged in the study of nervous diseases, must form my excuse for offering you a few remarks on this peculiar affection of the spinal cord. Syringomyelia, or the formation in the gray matter of one or more cavities with well-defined limits, is usually said to be due to one of two causes: (1) the persistence and further development of congenital abnormalities of the central canal, or (2) to the formation of a glioma which develops from embryonic neuroglia tissue, its central part dis-

integrating to form a cavity. But there is another view of the origin of this disease which, I believe, not uncommonly explains its formation, and for the suggestion of which let me take this opportunity of thanking my late Professor of Pathology, Dr. Teskey. This view is that the growth is really a cyst. There are many points in its anatomical nature which favour this opinion. The ramified prolongations seen in some of the sections recall forcibly to one's mind similar ramifications extending from the main cyst in cystic degeneration of a Graafian follicle. This mode of origin being accepted, we have a ready explanation of the constancy of the neuroglia tissue which surrounds the cyst in all parts. That this tissue can be regarded as largely of new growth is supported by the fact that there is an actual increase in the amount of tissue as well as a proportionate increase of it in the walls of the larger cavities; just as the wall of a large cyst is thicker than that of a small one. We know, too, that the tendency of cysts is to begin in normal spaces, such as the central canal or in foetal remains of it, and in this way we can readily account for the cavity arising not only in the central canal itself, but also in other parts of the gray matter. That cavities may arise in the gray matter as the result of central myelitis is quite possible; but such cavities present no well-defined walls, nor are they lined by a layer of columnar epithelium, and do not, I think, belong to true syringomyelia. The cavity most frequently begins in the median line of the posterior commissure. In shape it varies greatly. In some cases it is irregularly oval, giving off prolongations here and there, from which processes arise, reminding one of a branched tubular gland. In all cases it is lined by a layer of columnar epithelium, such as are found lining the central canal in the normal cord. That this layer of epithelium is not complete in all cases may be accounted for by the time after death at which the *post mortem* was made, or by the fact that it may have been destroyed by mechanical causes. This layer of epithelium rests upon a basis of well-defined neuroglia tissue of somewhat varied thickness, but always conspicuous by the absence of the essential nerve elements. The size of the cavity is also subject to much variation. In some cases it extends laterally, destroying

\*Read before the Ontario Medical Association.

more or less of the gray substance; while in others, much rarer cases, it extends backwards, involving the posterior columns. Descending degeneration and disseminated sclerosis are often present, as may be seen in the specimens. The symptoms of this disease are found only in the adult, and their distribution is symmetrical. The upper extremities are first attacked and suffer chiefly, owing to the greater development of the lesion in the cervical region which occurs in all cases. Sensory or motor disturbances may form the first indication of the disease. A slight wasting of the thenar and hypothenar eminences is often found early, but a change in the sensibility of the skin of the fingers perhaps more frequently attracts the attention of the patient. This sensory disturbance is peculiar in the fact that while the sensation of pain or of heat and cold is entirely lost, that of touch remains perfectly normal. This was well shown in one of Charcot's cases. The patient, a programme seller in one of the Parisian theatres, was a great cigarette smoker. He consulted Dr. Charcot on account of a burn which he unconsciously received while holding a lighted cigarette in his fingers. He was able to recognize perfectly well the position of the cigarette in his hand, but was wholly unaware that it was burning him. This disturbance of sensibility, beginning in the fingers, spreads gradually upwards, involving the entire surfaces of both arms, and sometimes also of part of the trunk. The wasting of the muscles and the motor paresis are quite similar to the corresponding changes seen in the ordinary form of progressive muscular atrophy. Scoliosis accompanies the disease in nearly all cases. A spastic rigidity of the legs is often present, being due to the secondary degeneration in the lateral columns. Atrophy of the muscles of the legs and the peculiar sensory disturbances, as seen in the upper extremities, is very rare, and only comes on late in the disease, when the affection has extended downwards to the lumbar region. Vasomotor and trophic disturbances are common. Differences in the size of the pupils are frequent, from the implication of the sympathetic in the cervical region, and the disseminated sclerosis would account for the nystagmus which is often present. The cause of the motor symptoms of this disease is not difficult to explain from the

implications of the large ganglion cells of the anterior horns. When examined with a microscope, some of these cells present a granular degeneration which entirely obscures the nucleus, while others are quite atrophied in their appearance. Since each motor fibre, from its origin in a large ganglion cell of the anterior horn to its termination in the muscle, is simply a prolonged and uninterrupted process of this cell, it is easy to understand that any irritation of the cell itself must cause a degenerative change in this process; and, further, that this change must first begin in that portion farthest removed from the nucleus which nourishes it, consequently, in its most peripheral part, or where the motor fibre joins the muscle.

The sensory symptoms are much less easily explained, owing to the discrepancies which exist in the statements of the various experimenters in regard to the functions of the different tracts of the cord. That the fibres for the conduction of pain and temperature run in different tracts from those which conduct ordinary tactile impressions receives much support from clinical phenomena. According to Brown-Séguard, the central part of the gray matter serves for the conduction of the sense of temperature, its posterior and lateral parts for that of pain, while the anterior columns of the cord convey tactile sensibility, all three forms previously decussating in the median line. Schiff states that the gray matter serves for the conduction of pain, but that tactile impressions are conveyed by the posterior columns. Dr. Gowers, as the result of his long and excellent experience, says that after their decussations in the posterior commissure, the fibres subserving sensibility to pain pass upwards in the antero-lateral ascending tract, and that those subserving temperature probably pass up in their immediate vicinity. With this assertion Ferrier does not agree, for he found on dividing the outer half of the lateral column in the spinal cord of monkey that there was no impairment of painful sensibility the day following the lesion. On the other hand, Gowers quotes a case of injury to the spinal cord in the upper cervical region of a man which involved the lateral column and gray matter, as the result of which there was an entire loss of sensibility to pain on the side of the body opposite to the lesion, with-

out any loss of tactile sensibility. Since this latter observation is due to a lesion of the cord in man, and since the testing of tactile impressions in animals is often difficult, I think we are more justified in accepting Gower's view than that of Ferrier's, especially when we consider that the course of the fibres in two cords, may possibly not be entirely analogous. Granting, therefore, that the antero-lateral ascending tract conveys the fibres subserving pain and temperature, the explanation of a part of the sensory phenomena of this disease is at once apparent. Since the lesion of syringomyelia is most advanced in the cervical cord, we have, in the destruction of the gray matter in this region, good reason for believing that the fibres for the conduction of pain and temperature are there interrupted, and this causes the abolition of these two forms of sensation in the upper extremities. That the legs are not so affected, or at least not until very late in the disease, would be accounted for by the very gradual descent of the lesion in the cord, and also by the fact that when the lesion is situated above the lumbar region conduction in the antero-lateral ascending tract is unaffected, and this tract would consequently conduct the sensory impressions from the legs in a perfectly normal manner. As regards tactile sensibility, experiments suggest that it is conducted by the posterior columns, and the integrity of these latter, especially in the earlier stages of the disease, would account for its retention in some cases. The same might be said of muscular sense, which is rarely affected. I might add that in the only case in which tactile sensibility was lost that Dr. Déjerine has met with, the autopsy showed a marked degeneration of the peripheral nerves.

The diagnosis of this disease, when the symptoms are well marked, is not difficult. The atrophy of the muscles, the peculiar disturbance of the sensibility, and the scoliosis form a characteristic group. From progressive muscular atrophy, in which the lesion in the muscles is like that of syringomyelia, the disturbances of sensibility form a marked contrast.

As regards Morvan's disease, much discussion has arisen as to whether it were not a form of syringomyelia, but Mr. Morvan assured me, on asking the question, that the two diseases were

both pathologically and clinically distinct. In Morvan's disease sensibility of *all* kinds is lost, but only over a limited area of the hand and forearm. In this disease, too, the patient usually consults a physician on account of one or more whitlows on the fingers, and the medical attendant is sometimes surprised to find that these are lanced without causing the slightest pain, although they are often sufficiently extensive to destroy the whole phalanx.

From cervical pachymeningitis, the diagnosis is sometimes difficult, but the early and severe pains which accompany this affection, together with the fact that it attacks in a remarkable manner the distribution of the ulnar and median nerves, will usually prevent error. The course of syringomyelia is usually very chronic, and its treatment in the main symptomatic.

#### WHOOPIING-COUGH: TREATMENT BY ONE OF THE NEWER METHODS.\*

BY DR. J. T. DUNCAN, TORONTO,

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The treatment of whooping-cough has never yet been perfectly satisfactory; has been, indeed, decidedly unsatisfactory. Many different medicines have been tried, some of them vaunted for a while, and then consigned to oblivion. And the long list of remedies is being constantly added to. Every year brings forth new specifics. Probably every practitioner present has made trial of these new remedies. The consensus of professional opinion is fairly set forth in the latest published book on the practice of medicine—I select one bearing the date 1892—that splendid work by the man who stands in the very forefront of his profession; a man whose name is a synonym for all that is best and most advanced in the treatment of disease; a man of whom all Canada is proud—I refer to Dr. Osler, of Baltimore. We may accept the utterance found in this work as embodying the opinion of the profession on this subject. On page 87 are the following words: "The medicinal treatment of whooping-cough is most unsatisfactory. Like other infectious disorders, it runs its course practically uninfluenced by drugs. . . . For the paroxysmal stage a suspiciously long list of

\*Read before the Ontario Medical Association.



remedies has been recommended, twenty-two in our popular text-books on therapeutics."

But granting the truth of this remark, that up to the present time no drug has been found to influence the course of whooping-cough to any extent, this does not prevent the hope that some means may be discovered. Speaking for myself, however, I may say that having tried a number of the new remedies as they appeared, and without much success, I had grown sceptical in regard to them. Therefore when, more than a year ago, I first saw mentioned the drug of which I am to speak to-day, I did not consider it worth while to try it. But last January, first in that valuable publication, the *Medical Annual*, published by Wright, of Bristol, and afterwards in the weekly epitome of the *British Medical Journal*, the drug bromoform was highly spoken of in the treatment of pertussis.

Having then a serious case on hand, I determined to try it. I will now give the brief record of five cases in the order of their occurrence treated by bromoform.

*Case 1.*—This was a delicate boy, *æt.* 4½ years. In February of this year he began to cough, and from the 11th to the 29th he was under the treatment recommended by Quain, viz., chloral hydrate, but without much improvement. The cough was so troublesome at night, the attacks being nearly one an hour, that the boy's father sat up sometimes till 6 o'clock in the morning with him. On the 29th of February, I ordered bromoform *mij* to *ijj* to be given in a teaspoonful of water three times a day. The night following the first day's administration was only marked by two paroxysms. Not only was the coughing thus reduced, but the vomiting, which had been severe, was rapidly lessened. On March 2nd, three days after getting this treatment, he was reported improved in every, and on March 4th as "much improved." From this time the improvement was rapid, and on March 8th he was stated to be "almost well." Shortly after this, however, partly because the slight remaining cough was no trouble, and partly from a strange fear of the medicine, he only received it about once a day. During the first two weeks of April he received none whatever, and the cough and vomiting returned. Bromoform was ordered again, and at my last visit, in the end of April, the cough was

so slight as to be scarcely noticeable, appetite good, and he was gaining in flesh.

*Case 2.*—Girl, *æt.* 4. In this case, the paroxysmal stage began about the middle of March. They were described by the mother as "very bad." Not very numerous, perhaps 15 in 24 hours; they were yet so severe as to cause fainting on several occasions, while vomiting took place with every paroxysm. She was said to be getting constantly worse. On the 30th of March I was asked to see her, and at once ordered bromoform *mij*, as in *Case No. 1*. The mother could not obtain the drug for some days, as it was not kept in all the stores. But after obtaining it, she reported a decided improvement in three days. The cough and vomiting lessened, and the vomiting entirely ceased in ten days after taking the first dose. The appetite also improved as the cough lessened. The cough entirely ceased about April 25th.

*Case 3.*—Boy, *æt.* about 5 years. In this case, the whoop began about March 25th. It seemed a mild case. Bromoform was ordered as before. The boy was sent to Muskoka, and I can only report that his friends told me he had little trouble.

*Case 4.*—Girl, *æt.* 2 years. Paroxysms began in the first week of April, occurring about every two hours, vomiting every time. She was losing her appetite. Here the medicine seemed to check the trouble at once. She was so well by the middle of April that the medicine was stopped. At the end of April there was an occasional cough remaining, but it gave no trouble.

The last record I can present is that of a baby.

*Case 5.*—Girl, 7 months old. The paroxysms were present for about a week before I saw her. Cough occurred ten or twelve times a day, appetite was almost gone, she was losing flesh. *Mj* was ordered three times a day. This was tried for four or five days without the slightest improvement. The dose was then increased to *mij*. Improvement was noticed the second day after receiving the larger dose. The paroxysms lessened in number and severity, and the appetite returned quickly to its excellent normal state. An occasional rather worrying cough still remained at the end of April.

Such has been my experience with this drug.

Allow me briefly to refer to that of others. Dr. Stepp seems to have used it in 1890, and claimed great success with it. Dr. Lowenthal next used it, and in the manner recommended by Dr. Stepp, viz., in doses of 2 to 5m three or four times a day. He says it exerts an almost specific action upon whooping-cough, at least if used early. One hundred cases were treated, æt. 8 weeks to 7 years. As a rule the good effects began to show themselves on the second or third day, the vomiting being arrested within a week after the commencement of the treatment. Complications ran a favorable course, and, where there were relapses, a return to the bromoform soon arrested the symptoms.

In the weekly epitome of *Current Medical Literature*, published as a supplement to the *British Medical Journal*, is this summary (Sept. 19th, 1891). Stepp has treated 100 cases, Lowenthal 100, Neumann 25, and Scheppers 250.

The results may be thus stated: (1) Bromoform in the doses stated is a perfectly harmless remedy. (2) The attacks diminish in number and severity. (3) The first paroxysmal vomiting disappears in two or three days. (4) Nasal and other forms of hemorrhage soon disappears. (5) It acts beneficially in complications, largely by giving affected organs, *eg.*, lungs, a chance to rest. (6) It undoubtedly shortens the duration of the attack (Stepp, 2 to 4 weeks; Scheppers, 8.)

Bromoform is a heavy sweetish liquid. It is best given dropped in a teaspoonful of water. Given thus, children like it; but be sure the drops are swallowed, as they sink through the water on to the spoon. It must be dispensed in small amounts, and kept from the light, as it is apt to change.

A PERMANENT FEHLING'S SOLUTION.—Fehling's solution by the usual formula is quite unstable. The following modification is suggested by Rossel in *Schweiz Wochenschr.*: 34.56 grains pure cupric sulphate are dissolved in some distilled water; 150.0 grammes glycerin and 130.0 grammes caustic potassa, and then made up to one litre. One c.cm. of this solution corresponds to 5 mg. of glucose. The solution is said to be a permanent one.—*Med. and Surg. Reporter.*

## Selections.

### CONDITIONS INDICATING CHANGE OF AIR AND BATHS IN THE SUMMER DIARRHŒA OF CHILDREN.\*

BY SIMON BARUCH, M.D., NEW YORK.

The removal of the causes of disease being the chief aim of modern therapy, the unsanitary conditions that actively contribute to the development and maintenance of the summer diarrhœa of children constitute an important element in the prophylaxis.

*Change of air* does not, as is sometimes erroneously supposed, improve the condition of the sick child by reason of any special difference in the proportions of oxygen or other chemic constituent. The chief factors that warrant us in advising change of air are (1) high temperature and marked humidity, or both; (2) the presence of impurities.

The pronounced influence of high atmospheric temperature and extreme humidity in the causation and maintenance of summer diarrhœa in children has long been observed. Whenever, therefore, the usual treatment seems unavailing, especially when extreme prostration, with or without febrile exacerbations, becomes an element in a case of summer diarrhœa, the question of change of air becomes important. Of what avail are stimulants, tonics, and food when the little sufferer is forced to toss under the constant, relentless systemic oppression produced by a stifling atmosphere, especially if aggravated by an excess of moisture, from which there is no escape, even by the most careful ventilation? Rich and poor are alike crushed under this terrible combination; for even in the open parks of the city it operates in full force. Removal by a rapid and comfortable journey to high altitudes or seaside, sufficiently remote to furnish a complete change from one or both of these prejudicial atmospheric conditions, becomes imperative in many cases. The change in the entire aspect of a case of summer diarrhœa under such favoring conditions has been so often observed that I need not emphasize its importance.

\* Read before the Pediatric Section of the New York Academy of Medicine, May 12, 1892.

The existence of atmospheric impurities demands removal of the little patient. Among the well-to-do classes atmospheric impurities are rarely operative in summer. Change of air will rarely be required in this class of patients. How different is it among the poor! The noisome tenements in which the children of the poor, and many even of the better class of working people, are huddled together are excellent places for the culture and propagation of the elements that contribute to the development and maintenance of summer diarrhoea in children. The chief aim in the treatment of the latter is now recognized to be clean food taken into a clean stomach, and its detritus removed as far as possible through a clean intestinal tract. The difficulty of meeting these indications in apartments abounding in dust and emanations from numerous human beings crowded together need but be referred to. Hence, removal from the influence of this prominent etiological factor becomes imperative, not for the purpose of securing, as was formerly held, air containing more oxygen, but with a view of having the patient surrounded by air containing less filth and its accompanying bacteria. While a change is imperative in almost all cases of summer diarrhoea of the children residing in crowded tenement houses, it is not so important in those cases whose environment is more favorable for home treatment. Indeed, the change from a comfortable home to a country hotel, which is apt to be overcrowded, is not to be advised without careful reflection. It is not an infrequent occurrence to order a sick child away when the symptoms become alarming without time for preparation or due inquiry. The consequences are discomfort from immaturity of plans, great expense, disturbance of the family, and consequent anxiety and unhappiness for the parents and friends.

Do the benefits to accrue to the little patients warrant these? The advantages and disadvantages of removal should be well weighed ere a change of air is decided upon; but, above all things, we must be satisfied that we have exhausted all other treatment. As I have said already, careful attention to sterilization of the food and to intestinal irrigation are of far greater importance than change of air. *We should be sure that these have been fairly tried before advis-*

*ing the change.* This statement is made as the result of practical observations at a noted summer resort, where I see many such cases every summer. To illustrate: In the summer of 1890 I was asked by Dr. Alfred Meyer, who was ill, to see for him a wizen-faced infant whose mother, being poor, had, at great sacrifice, brought it to a third-rate hotel at Long Branch for change of air as a last resort. The child had not improved simply because its food was not proper and its intestinal canal had not been flushed. One dose of castor oil, followed by two intestinal irrigations, and the use of sterilized milk, obtained by converting her medicine bottles and saucepan into a sterilizer, brought about a rapid recovery, enhanced by the constant exposure of the infant to the pure, ozone-laden air. Last summer I was called to the Long Branch home of the Babies' Shelter of New York to see two children whose diarrhoea had not improved under the best dietetic and medicinal care in the city and after several weeks' residence in the country. A few intestinal irrigations sufficed to make a complete change in these cases, and contributed more to their recovery than change of air had done. The lesson from such cases is evident. While all cases of summer diarrhoea of infants living in crowded houses demand change of air, other treatment is at least equally important. Among the better-situated change of air need not be insisted upon until all approved methods of treatment have been fairly tried.

*Conditions indicating Baths.*—Baths for cleanliness are always demanded in summer diarrhoea, not only because the frequent soiling renders them more necessary, but because the maintenance of the functions of the skin seems to relieve internal congestion and fluxion.

In acute cholera infantum baths for therapeutic purposes are of paramount importance, affording more positive relief and contributing more to the cure than all other measures. This form of summer diarrhoea has by some not inaptly been regarded as a type of heat-stroke. Certain it is that if the temperature is taken in the rectum it will almost always be found high; not infrequently there is hyperpyrexia, though the skin of the extremities and face be cool and clammy. Whenever the temperature exceeds 102° F., a cooling procedure is indicated. It is

important that the proper method of bathing should be adopted, and that its *rationale* be well understood.

In these cases there is usually profound involvement of the nervous system, frequently manifested by a dull, apathetic countenance, sunken eyes, deadly pallor, cool extremities, not rarely terminating in outspoken eclamptic seizures. Medicines and stimulants are useless, because the stomach and rectum do not tolerate them. Such a child should be put at full length into a tub of water at 90°, after its face and head have been bathed with ice-water; gentle friction should be constantly made while some one is removing with a pitcher the tepid water and replacing it by ice-water poured over the side of the tub farthest from the patient's body. The temperature of the bath is thus gradually lowered to 80°. If there be marked cerebral disturbance, water at 60° may be poured upon the head and shoulders. The child's body must be entirely submerged, the head only not being immersed. Its cries and protestations of chilliness must be met with gentleness, yet with firmness. For fifteen minutes the agitation of the water and friction of the body should be kept up, unless cyanosis of the face or decided shivering ensues. The latter will be prevented by active friction, which stimulates the peripheral circulation.

After the bath the child is placed upon a linen sheet, previously laid smoothly upon a blanket. If the temperature before the bath—and it should always be taken at this time—has been 103.5° or higher, the child should be wrapped in the sheet so that every part of the body and extremities is well covered by it; the blanket is now snugly wrapped over and tucked under the body, which is thus allowed to dry. If, on the contrary, the temperature has been below 103.5°, the child should be gently mopped dry and its clothing be replaced at once. Such a bath is almost invariably followed by calm and refreshing slumber, from which the child awakens bright and playful.

Let it be understood that the object of this bath is not to reduce temperature, although this is an important incidental result. We have here a vaso-motor paralysis, as evidenced by the pallor of the entire body, even when a high temperature is registered in the rectum. By im-

mersing the entire body in tepid water we produce a mild shock, which is gradually increased by the removal of warm and the addition of cold water, and is enhanced by frictions of the body and constant agitation of the cooling water against the skin. These gentle shocks are succeeded by equally gentle reactions, so that the cutaneous vessels dilate, as evidenced by redness of the skin. If, in addition, the face and head are bathed with a little colder water, at 60°, the shock and reaction are increased, the respiration deepens, the heart beats with more vigor and less rapidity, the eye brightens, the color returns to the lips, the child becomes more animated.

The effect of a skilfully-administered bath in the condition of nerve prostration incident, in many children, to acute summer diarrhoea must be observed to be fully appreciated. In my experience it has been an inestimable boon, affording hope and comfort under the most trying and desperate conditions. My mind still retains vivid recollections of the days when I was a student and of the early years of my practice, when the condition of profound adynamia, usually associated with hyperpyrexia, was called spurious hydrocephalus, and the cases were allowed to die under blisters to the nucha and small doses of calomel. These cases do not now come under my observation; they are forestalled by the bath and by more rational treatment, foremost in which is judicious gastrointestinal irrigation.

When there is objection or prejudice to tub-bathing, or when there is extreme jactitation, or when there are convulsions, the little patient may be placed in the wet pack, or the bath may be followed by the latter to maintain the calming effect. The wet pack is prepared by wringing out of water at a temperature of from 50° to 60° a linen sheet folded into a third of its usual size and smoothly laid (folded to suit the size of the child) upon a blanket. The child is snugly wrapped in the damp sheet (which may be made more wet if the temperature be high), so that the arms receive a fold to separate them from the body, and the legs a fold to separate them from each other. The blanket is now snugly tucked around the child, so as to completely envelop it, like a mummy, to prevent evaporation. This pack may be repeated two or three times, at intervals of ten minutes. The previ-

ously tossing child will usually drop into tranquil slumber, from which it should not be aroused. After the wet pack the body should always be rubbed with a linen cloth not quite wrung out of water at 70° F., and dried.

In the subacute form of summer diarrhoea, the chief condition indicating baths is the general depression of the system arising from the great drain upon the blood and nervous system. The pulse is usually rapid; the temperature ranges from 99° to 101°, with occasional exacerbations; the skin is inelastic; the face is sallow; in short, the symptoms are those of chronic adynamia, due to imperfect nutrition. To stimulate the appetite, improve the general nervous condition—in a word, to refresh the entire organism—should be our therapeutic endeavor. The most approved tonics and stimulants often fail. In these cases general ablutions, morning and evening, are preferable to baths. The child is placed upon a soft woollen blanket; the abdomen, chest, and back are rapidly bathed, not sponged, as follows: From the hollow of the naked hand water at a temperature of 75° F. is poured upon the skin, which is then gently rubbed with the same hand. This is repeated until the entire body has been thus treated as far as the knees and elbows. The body is now rapidly dried by placing it upon a linen sheet, using friction with a rough towel if the temperature is below 99° F., and only gentle mopping if it is above 100° F. If the temperature reaches 102°, a general bath is indicated, beginning with water at a temperature of 95°, which is gradually reduced by agitation and friction to 85°. Gentle drying follows.

The refreshing effect of these procedures has been so frequently observed that I do not hesitate to commend them to your adoption. There are many modifications of baths indicated by the various symptoms in summer diarrhoea of infants. Suffice it to say that no case should be regarded as intractable or too desperate until some form of hydiatric procedure (the adaptation of which to each case often requires more judgment than that of medicinal agents) has been tried.—*Medical News*.

A CASE OF STRICTURE OF THE PYLORUS RESULTING FROM GALL STONE.—A.B., æt. 58; Irish; stoker: during January complained of

dull pain in the right side in the mammary and hypochondriac regions, the pains occasionally extending to the right shoulder. Obstinate constipation and persistent vomiting, with these pains, constituted the symptoms for several weeks preceding. No family history obtainable. He gave a history of gonorrhoea and the primary and secondary signs of syphilis in his younger years. From the gonorrhoea resulted an urethral stricture which had occasionally caused partial or complete retention of urine. During the past few years he had a number of attacks of pain of considerable severity in the right side, which, however, did not confine him to bed. In March, 1891, he had a severe illness, when the chief source of complaint was an acute pain in the left chest, extending downward to the epigastrium. Toward the end of 1891 he began to fail; the pains in the right side became more continuous and troublesome; anorexia was marked; bowels constipated. Vomiting now set in. When he came under observation in January, 1892, his general condition was very poor; he was greatly emaciated, and had a decided cachectic appearance. Vomiting was constant, and he was unable to retain food or medicine. Vomitus was thin mucus, tinged green with bile, and of a very offensive, sourish odor. No bloody or "coffee grounds" vomit ever noticed. Bowels were constipated and difficult to move by medicines or enemata. The stools were normal in color. Physical examination: Lungs normal; abdomen greatly retracted; upper line of liver dullness a little high; the lower margin of liver could be felt an inch below the chondral cartilages. The gall bladder could not be made out. Percussion gave stomach resonance high up, and over a wide area. Palpation of stomach gave negative results. Scars over tibiæ that were plainly syphilitic. Urine, normal color; turbid; strongly acid; sp. gr. 1014; trace of albumen. Sediment showed pus corpuscles and kidney and bladder epithelium, but no casts were found. Rectal feeding and medication proved futile, and on February 25th the man died, apparently of inanition. Diagnosis at that time: Stricture of the pylorus, due probably to carcinoma or syphilitic gumma. *Post mortem*, twenty-four hours after death: Body greatly emaciated. Lungs, pleural adhesions extensive over right lung; about a pint of fluid in the left chest.

Kidneys small, capsule adherent, cortical portion very narrow. Liver about normal in size; surface covered with the cicatrices of an old perihepatitis. Stomach considerably dilated; the pyloric end lying adjacent to the gall bladder. The mucous membrane was rather pale and covered with a yellowish, tenacious, offensive smelling mucus, but not markedly diseased in any part. On attempting to pass the finger through the pyloric opening it was found that the outlet was nearly closed by some constricting bands about its external or peritoneal surface. Using considerable force, thereby tearing their constricting fibres, the index finger could be forced through into the duodenum. A hard lump in the midst of a mass of adherent viscera at the site of the gall bladder proved to be viscus contracted to about the size of a large pigeon egg, and inclosing tightly a calculus of the size just mentioned. This calculus, when dried, had a dark-brown exterior, rather brittle, and when cut transversely showed a nucleus the size of a hazel nut, dark colored and structureless; around this core are shown arranged in concentric circles layers of bright yellow inspissated bile, each separated from the succeeding layers by a whitish or a dark narrow zone. The gall bladder walls were thickened, and it had lost all resemblance to its normal appearance by being enclosed in a mass of tough fibrous connective tissue, which bound together all the parts in relation to that viscus. The lower surface of the right lobe of the liver, on either side of the cystic fissure, the hepatic flexure of the colon, the anterior wall of the abdomen, and the pyloric end of the stomach were attached to, enclosed, and tightly drawn by these connective tissue bands. The presence of the gall stone had evidently set up a chronic inflammatory process about the gall bladder, plastic lymph was thrown out, which in course of time contracted, and the pyloric end of the stomach happening to be involved in this cicatricial contraction, stricture of its lumen resulted necessarily. No carcinomatous processes nor syphilitic gummata were discovered anywhere.—*J. C. Falk, M.D., Ph.G., in the Medical Fortnightly.*

REMARKS ON THE EVACUATION OF DÉBRIS AFTER LITHOTRITY. — Surgeon-Major Forbes Keith having described in *The Lancet* of June

11th, 1892, a method of removing stone fragments after lithotripsy other than by the process of evacuation with the aspirators at present in vogue, I will describe a procedure I have seen during the last twelve months at M. Guyon's clinic at the Necker Hospital and elsewhere in his practice, which seems to possess certain advantages. I have adopted it myself to some extent and I know that other surgeons think favorably of it. There can be no doubt that the shortcomings of lithotripsy are chiefly connected with the difficulty existing of guaranteeing that every fragment, however small, is removed and that nothing is left behind on the completion of a crushing operation which is capable of furnishing a starting point for another concretion. Of all the conditions favorable to the reproduction of stone this is probably the most fertile one, and all proposals tending to diminish the liability in this direction are deserving of careful consideration. M. Guyon's practice, as I have now observed it on several occasions in public and private work, is as follows: The patient being fully anesthetized, the fenestrated lithotrite is introduced, and the stone is not merely broken up but absolutely pulverized. In the last case I saw, a urate-phosphate stone with a diameter which only just brought it within the grasp of the largest lithotrite, was subjected to a process of trituration which lasted for twenty-five minutes by my watch, without, I believe—as far as I can remember—a single withdrawal of the instrument. When no fragments could be felt with the lithotrite the evacuating catheter was introduced. The latter consisted of a full-sized instrument with a large eye on either side of the beak. No aspirator was attached to it such as we are in the habit of using for withdrawing fragments by suction-pressure, but after the bladder had been allowed to empty itself spontaneously of its contents by the catheter an ordinary syringe was attached to the latter and about six ounces of warm boracic lotion were gently injected. Then the syringe was disconnected and the bladder allowed to empty itself, this process being continued until the contents of the syringe were returned absolutely pure. The bladder was finally washed out with a solution of nitrate of silver (1 per 1000) and a rubber drainage catheter was passed and retained for twenty-four hours. The opera-

tion was completed in forty minutes and considerably over an ounce of stone powder was withdrawn suspended in boracic lotion. The total amount of blood was little more than sufficient to color the water and entirely disappeared before the syringing was completed. I examined the debris after it had all been collected. In its moist state it had the appearance and feel of soft homogeneous mud. There were no appreciable fragments of stone in it. The following were the points noticeable in this and similar procedures, as elsewhere observed: (1) The use of the lithotrite to produce this effect was necessarily more prolonged than where mere fragmentation is the object. This, with the patient under an anæsthetic, is a matter of no importance so long as the lithotrite is carefully used. (2) The less frequent introduction of lithotrites and evacuating catheters along the urethra. This is a point of some little importance where the prostate is large and the deep urethra irregular. (3) The back action of the suction apparatus, by means of which fragments of stone often become impacted in the sacculæ and lacunæ which are found in bladders complicated with enlarged and irregular prostates, is done away with. The force of a syringe is probably less than that of the back action of a strong rubber bag compressed by the hand. Further, impalpable wet powder is substituted for irregular fragments of stone. The latter by their nature are not only more liable to become impacted in depressions within the bladder wall, but, by their movements under the force of the aspirator, to wound the mucous membrane, as illustrated particularly by Surgeon-Major Keith in the paper referred to. (4) With the syringe there is no chance of fragments once withdrawn being washed back by any return current into the bladder. No aspirator that I have yet seen is free from this objection. I am not aware that there are at present any statistics indicating the relative frequency of recurrence after these two methods. That the subject is worthy of careful consideration is evident from the large number of recurrences which follow lithotripsy, more particularly in those cases which are further complicated with conditions rendering the patient completely dependent on the use of the catheter.—*Reginald Harrison, F.R.C.S. Eng., in The Lancet.*

ASEPSIS AND ANTISEPSIS IN MIDWIFERY.—A most suggestive monograph from the Dresden Frauenklinik, "On the prevention of Puerperal Fever," embodying the methods and results in that institution during the last six years, and coming at the psychological moment when the scope of antiseptics in obstetrics is being determined by the experience of workers over all the world.

Clinical and bacteriological studies are daily amplifying the knowledge of possible sources of infection, and suggesting new procedures calculated to yet more rigidly exclude the danger of sepsis. The paper before us compares the results of careful abdominal palpation anterior to labor, an absence of vaginal examination during parturition, and an entire abstention from vaginal douching during the puerperium, with ordinary internal examination for diagnosis, and vaginal irrigation in the usual manner in the days succeeding delivery.

Tabulated statistics for the three years ending in 1888, and during which vaginal washing was a routine procedure, are arrayed side by side with the percentage results of the three years ending in 1891, no douching being practised during the latter period. As the average number of deliveries was 1350 per annum, the data seems fairly comprehensive, and the former triennium shows about 80 per cent. of apyretic puerperia, as against the marked advance to 90 per cent. during the latter time. Immediately the vaginal irrigations were excluded, the normal puerperia increased by 10 per cent.

Combined with the cessation of the use of sublimate douches was the almost entire substitution of abdominal palpation for vaginal examination. To those who know the care and detail with which this method is carried out on the Continent, its usefulness will not be strange. The authors urge that every opportunity should be seized for its development, and that, in the majority of cases, no supplementary internal investigation is required. They attribute high importance in the prevention of puerperal fever to this substituted procedure, and state, in set terms, that those puerpera internally examined by even an aseptic finger have a notably less favorable convalescence than those examined by abdominal palpation only.

The scheme recommended by the authors as

the net product of their extensive experience, consists of internal examination as little as possible, and external examination as much as possible, the most careful personal antisepsis, scrupulous cleansing of the external genitalia during the whole puerperium, and especially careful cleansing and disinfection of the vulva and its surroundings before every internal examination.

The paper abounds in statistics and technical data, and the time-period embraced in the communication has been thoroughly analyzed for facts and indications.—*Med. Chron.*

A MODEL TO IMITATE.—There are a great many peculiarities reported of men of genius. Sir Isaac Newton was a vegetarian; General "Stonewall" Jackson thought one side of his body was heavier than the other, and always carried a weight in his pocket; Schopenhauer played the guitar; Erasmus would not eat fish; and Dr. Johnson never took a walk without touching the lamp-posts. But we learn that the peculiarity of Mr. Gladstone's greatness is more curious and subtle than that of any of his predecessors. Every bolus of food which he takes is chewed thirty-two times! Why thirty-two instead of thirty-nine, which is the number of the Articles, or thirty, which is the number of the days of the month, or some other number which has a specific significance, has not been explained. Perhaps some time the Grand Old Man will leave his Homeric and Celtic studies for an elucidation of these more serious problems. We are, however, not disposed to quarrel with thirty-two. It is a good number, and one which ought to secure thoroughly pultaceous mastication, and a completely saturated insalivation, besides exercising the masseters, temporals, external and internal pterygoids, and securing time for a pleasing gratification of the sense of taste. There are a great many things making up the admirable character of Mr. Gladstone which cannot be imitated, however desirable that might be. But his two-and-thirty method of mastication can be followed, and would have important influences upon the health and happiness of Americans if it were done. Dyspepsia, biliousness, headaches, neurasthenia, insanity, and bad temper would decrease, and perhaps disappear. We commend the methods of oper-

ation upon the food bolus adopted by Mr. Gladstone. If humanity imitates it we can truly say: *Exegi monumentum ære perennius*, no matter what becomes of the Irish.—*Med. Rec.*

THE SOURCE OF HALF THE WORLD'S UNHAPPINESS.—"The longer I live," said Sydney Smith (in good health), "the more I am convinced that half the unhappiness of the world proceeds from little stoppages, from a duct choked up, from a vexed duodenum or an agitated pylorus. My friend sups late; he eats some strong soup, then a lobster, then some tart, and he dilutes these esculent varieties with wine. The next day I call upon him. He is going to sell his house in London and retire into the country. He is alarmed for his eldest daughter's health; his expenses are hourly increasing, and nothing but a timely retreat can save him from ruin. All this is the lobster; and when over-excited nature has had time to manage this incumbrance, the daughter recovers, the finances are in good order, and every rural idea is effectually excluded from his mind. In the same manner old friendships are destroyed by toasted cheese, and hard-salted meat has led to suicide. Unpleasant feelings of the body produce corresponding sensations in the mind, and a great scene of wretchedness is sketched out by a morsel of indigestible and misguided food."—*Annals of Hygiene.*

THE American Medical Association, at its recent meeting in Detroit, adopted a resolution, introduced by Dr. Charles A. L. Reed, of Cincinnati, looking to the annexation of Canada, at least the medical portion thereof, to the United States. In other words, should this amendment to the by-laws prevail, the Dominion of Canada will be embraced in the jurisdiction of the American Medical Association, and we may soon expect to see the Canadian profession walking arm-in-arm with our own down the aisles at the meetings. At the Detroit meeting many distinguished physicians from Canada attended by invitation and took part in the work of the sections. It looks as though they would soon take their places as members, with all the rights and privileges pertaining to those in the United States, to which they will assuredly be very welcome.—*Buffalo Med. and Surg. Jour.*



THE LEGAL LIABILITY OF HOSPITALS.—On the 16th May the Court of Common Pleas of New York added another decision to the interesting question of the legal liability of hospitals. The question, in brief, is: Is a hospital corporation legally responsible for injury to a patient? In one case the suit was brought against the Manhattan Eye and Ear Hospital. The plaintiff's eye was operated upon at this institution, and he showed that the after-treatment was not of a proper character. As a result there was entire loss of sight from the eye. The first trial resulted in favor of the plaintiff; but the General Term of the Supreme Court reversed this decision, holding that no cause of action had been made out. The position of the court was this: Inasmuch as the corporation had exercised all proper care in the selection and appointment of the physicians of the institution, it, being a public charity, was not liable. To recover against the hospital it must be proved that there was an omission to exercise due care in the selection of the persons in its employment. In the case just decided the plaintiff's son was treated for an injury to his thigh, and owing to the alleged negligence of the surgeons of the institution, the Society of the New York Hospital, there was not a good recovery. The hospital authorities simply showed that they were a public charity, and that they had used all possible care to select competent physicians and surgeons. Upon this showing alone the court dismissed the complaint.—*New Orleans Med. and Surg. Journal.*

RECOVERY AFTER TAKING A LARGE QUANTITY OF VERATRUM VIRIDE.—Mr. A. was attacked on February 5th with severe epididymitis and orchitis. That night his brother came to me, saying that his fever was very high and that he was suffering a great deal of pain. I prescribed for him "tr. verat. virid. (Norwood's), fʒiv. Sig.: Two drops every half hour until perspiration is well established." The patient read the directions *two teaspoonfuls* every half hour, and took the first dose accordingly at 8.30 p.m. This he retained without any appreciable effect until 9.05 p.m., when he took the second dose of two teaspoonfuls. In about half an hour he "began to vomit, and became very weak," as he described himself. On the following morning I was called to see him, and having heard his story of how

he took the medicine, was more surprised to find him alive than that he was exceedingly weak and very pale. The heart was feeble but regular, and the respiration very nearly normal. A small quantity of whisky and infusion of digitalis were given, and the patient recovered without any unusual symptoms. The prescription was compounded by a reputable pharmacist, who assured me that he had dispensed the stronger tincture. The interest in the case centres in the remarkable fact of the patient's having retained so large a quantity of the drug for nearly an hour without any disastrous effects.—*James P. Tuttle, M.D., in New York Med. Journal.*

ON THE DANGERS OF WASHING OUT THE STOMACH.—In the current number of the *London Practitioner* there is a valuable and timely article by Dr. Soltan Fenwick, of London, on the dangers of washing out the stomach. After pointing out the usefulness of this therapeutic measure in suitable cases he deals with the dangers attending it, and the harmfulness arising from its employment in unsuitable cases. Twenty-five cases of convulsive seizures in chronic diseases of the stomach are collected, and in six of these the attacks were apparently brought on by the use of the stomach tube. Both general convulsive seizures and tetany may be brought about by any irritation other than by mechanical means of the gastro-intestinal canal, but in some cases reported by Dr. Fenwick it is impossible to eliminate the stomach tube as being the active factor. Tetany arising from gastric disturbance is very fatal, upwards of 60 per cent. proving fatal. A case of perforation of a gastric ulcer occurring immediately after the use of the stomach tube is reported. Hemorrhage from the use of the stomach pump is not uncommon in cases where there is at the time ulceration of the mucous membrane, as in carcinoma and chronic ulcer. *Montreal Medical Journal.*

TRICHINOSIS OF THE TONGUE.—A curious and interesting case, albeit somewhat difficult to understand, is recorded by Dr. Oitiz of Toire. The patient was a man, *æt.* 50, a robust countryman, with no history of syphilis nor of tuberculosis, who came for advice with an ulcerated growth of his tongue. The disease had been in

progress about a year, and presented the characters of an epithelioma. Some misgivings, however, were expressed about the precise diagnosis, inasmuch as the ulceration was not of that foul nature such as usually occurs in connection with malignant disease. No improvement having followed the treatment adopted after a trial of a fortnight, it was decided to amputate the tongue. This was successfully performed, and on examination of the organ subsequently, the disease was found to be trichinosis, ulceration of the thickened tissue around the cysts having taken place.—*Medical Press.*

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THE  
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
OF THE MEDICAL SCIENCES.

*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.*

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TORONTO, JULY 16, 1892.

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DRAINAGE IN SALPINGITIS AND  
PERITONITIS.

No subject, in recent years, has attracted more attention than the treatment of the diseases of the uterine appendages. Our knowledge of the condition of things in periuterine inflammations is much more exact than it was a few years ago. It is now generally admitted that pelvic cellulitis, as formerly understood, is comparatively rare. Some go so far as to deny its existence, except in a very small proportion of cases in which it occurs after parturition. Without discussing any debatable points connected with this subject, we have to recognize the fact that, in a large number of women invalidated through pelvic inflammations, the Fallopian tubes have been converted into abscesses. Lawson Tait, and a number of his co-workers in abdominal surgery, tell us that nothing short of the complete removal of the uterine appendages, under such circumstances,

will effect a cure. We never had any sympathy with the craze which impelled many to remove all sorts and conditions of tubes and ovaries for simple pelvic pains and backaches; but we believe the removal of pus tubes is perfectly justifiable, and, in a large proportion of cases, the only procedure that is likely to effect any permanent good.

This operation, however, involves so sad a mutilation that many are quite unable to grow enthusiastic over it. Among the most conservative of modern gynecologists is Dr. W. M. Polk, of New York, who has uttered many words of wisdom on this subject during the last few years. In an article published in the *New York Journal of Gynecology and Obstetrics*, May, 1892, he refers to his method of treating such cases by means of drainage, with gauze packing. He admits that nothing but the removal of the appendages will relieve the symptoms in many cases. He considers that our knowledge is not as yet sufficient to enable us to decide in any particular case that the radical operation is necessary, and makes it a rule always to try certain less radical methods first.

His routine treatment includes rest, saline purgatives, hot water douches, and glycerinized tampons for a certain time, the length of which will largely depend on the amount of periuterine tenderness. After the completion of this *old-fashioned* line of treatment, he proceeds to pack the uterus with gauze. This he considers an *operation* involving certain risks if not carefully performed with the strictest antiseptic precautions. His directions epitomized are as follows: Cleanse the vulva, the vagina, and the cervical canal as for hysterectomy; dilate the cervix; introduce a cervical speculum having an inside diameter of five-sixteenths of an inch; irrigate interior of uterus; use sharp curette over the whole of the interior of uterus; irrigate again; pass a strip of iodoform gauze, which has been previously soaked in a bichloride solution and then rinsed in hot water, into the uterus with a Sims tampon screw, filling the cavity completely; bring the end of the strip out into the vagina and coil it up against the cervix; place a second piece of gauze loosely in the vagina. An anæsthetic is necessary in the majority of cases (in not less than 75 per cent.). The full details will be found in the February

number of the *New York Journal of Gynecology and Obstetrics*. He carries out this line of treatment in cases of chronic endometritis, chronic metritis (subinvolution), and chronic metritis with associated salpingitis. He chooses as the best time for his treatment the period immediately antecedent to menstruation.

Dr. Polk's contention is that his methods will frequently cure periuterine inflammations, including pyosalpinx. He acknowledges that in a certain proportion of cases they are not successful, but he insists that they always cause a diminution of the periuterine masses produced by uterine inflammatory exudations. He thinks his results show that such a course of treatment as he advises improves the condition of things in the pelvis, and gives a better chance for laparotomy when it becomes necessary. His efforts are certainly in the right direction, and his views on the subject are worthy of very careful consideration.

#### ANÆSTHESIA BY CHLOROFORM.

In some of the journals a spattering fire of assaults and rejoinders is still being kept up pro and con on the question of chloroform versus ether for anæsthetic purposes. The time that has elapsed since the report of the Hyderabad commission would seem to have been long enough to have settled the opinions of every authority, but the champions of each side are still trying to convict, if not to convert, the other. The point at issue seems to be whether or not death by chloroform is due to respiratory or to cardiac failure, the corollary being, of course, whether or not the anæsthetist, when using chloroform, should devote his whole attention to the breathing and let the pulse alone. As a matter of ordinary practice and of ordinary sense, no anæsthetist while giving chloroform, we suppose, ever does confine his watch to one danger signal. There are at least four points which should be, in every case, carefully attended to, in addition to the careful support of the lower jaw, either by the point or by the two angles, preferably, perhaps, the latter, thus supporting the hyoid bone with its attached muscles, and the base of the tongue, and leaving the entrance to the larynx free. These four points may be stated as follows: (a) During the onset

of the second stage the heart should be carefully watched, as the manner of its settling down after the preliminary excitement gives often a valuable hint as to what is to follow. If from being rapid and bounding the pulse slows too quickly and becomes irregular, danger is ahead, probably for the respiratory centre as well. It may be taken as established that while death does sometimes occur from cardiac failure, its most frequent cause altogether is respiratory failure. (b) The respiration should be watched, especially as the stage of profound anæsthesia is approached. Inequality of rhythm and variations in depth may indicate impending failure or only an attack of vomiting. If two or three successive respirations are seen to be each shallower than the last, the anæsthetic should be continued very cautiously, as failure may occur even if the mask be at once removed. It seems that vomiting is heralded more commonly by a respiration which shows increasing rapidity, and preponderance of inspiration over expiration, at any rate as regards effort and sound, if not also as regards amount of air. It is almost unnecessary to remind the reader that mere abdominal movement is no proof of respiration, as the diaphragm may still be acting and no air entering the glottis. (c) The pupil is a signal that probably no one ever neglects to watch carefully. (d) Lastly, the color. It takes very little experience to teach one to watch the condition of the capillary circulation as a sign of the true state of affairs, or to recognize the impending catastrophe in the ashy deathlike paleness of lips and face, with, perhaps, a slight toxic sweating or clamminess. If even a vestige of color remain in one cheek, returning easily after slight pinching, alarm is unnecessary, other signs being taken into account at the same time, for of course no one dare pin his faith to a single signal, but must have all the time under the most careful scrutiny the *tout ensemble* presented by a patient who, at the very best, is hovering on the confines of the nether world.

THE late Dr. D. Hayes Agnew, of Philadelphia, left an estate valued at \$250,000. He bequeathed to the University of Pennsylvania \$50,000, his work on surgery, library, and anatomical collections.

## Meeting of Medical Societies.

### CLINICAL SOCIETY OF MARYLAND.

W. T. WATSON, *Secretary.*

Baltimore, May 20th, 1892.

The 267th regular meeting was called to order by the president, Robert W. Johnson.

Dr. H. O. Reik, 1525 N. Carolina St., Baltimore, was elected to membership.

Dr. Samuel Theobald related

A CASE IN WHICH THE ELECTRO-MAGNET WAS EMPLOYED SUCCESSFULLY FOR THE REMOVAL OF A FRAGMENT OF STEEL FROM THE VITREOUS CHAMBER OF THE EYE.

A lad of 12 years of age, while using a hammer, struck a small piece of steel, which penetrated the eye and lodged in the vitreous chamber. The case was first seen in six days after the accident. The fragment penetrated the upper margin of the cornea, and just in line with this was a hole through the iris as large as a pin's head. The eye was markedly injected with evidences of perhaps commencing iritis. In vitreous humor, diffused opacity and numerous floating opacities. There was a punctate opacity on the anterior surface of the lens where it had been touched by the foreign body. Details of fundus could not be seen. The foreign body was not visible. Vision, 16-125ths. Operation 5 days after the patient was first seen, or 11 days after the accident: The injection increased and iritis had begun. Incision about 4 m.m. in length through the sclerotic, between the external and inferior rectus muscles. A Hirshberg's electro-magnet was employed. A single cell of the battery was used; this enabled the magnet to lift up a tack hammer. The point of the magnet was introduced well into the vitreous humor three or four times without success, but finally it brought out the little particle of steel the size of a pin's head. The conjunctival wound was stitched, and an opium and boracic acid lotion with compress was used. Atropia kept the pupil dilated. Boy suffered very little. Seventeen days after the operation he left the hospital, at which time the injection was very much less, the vitreous had cleared up very materially, and vision was 16-45ths. At the present time, 44 days after operation, the fundus of the eye can be seen with perfect ease. There are one or two floating opacities in the vitreous humor. Vision, 16-30ths.

Dr. Robert Randolph: This case is one of a very large class, forming the larger number of cases which come to us for enucleation and the

larger number which end in sympathetic ophthalmia. We have here a better method of dealing with such cases. When we have a reasonable idea of the location of the foreign body and under strict antiseptic precautions the operation is indicated, and there are a sufficient number of cases on record to justify us in looking for a happy issue.

Dr. Kate Campbell Hurd read a paper on

TREATMENT OF SPINAL CURVATURE BY THE ZANDER METHOD.

Dr. J. H. Branham reported a case in which

A SEA-TANGLE TENT WAS FORCED INTO DOUGLAS' CUL DE SAC IN AN ATTEMPT TO PRODUCE ABORTION.

On Feb. 27th, 6 p.m., saw in consultation a young married woman of 24, mother of three children. She had been about two months pregnant, and had attempted to produce an abortion on herself with a sea-tangle tent three days before I saw her. After leaving it for twenty-four hours she tried to remove it, but simply pulled out the string. Next morning her physician was summoned, but failed to find the tent, although the uterus was partly dilated and from it issued a badly-smelling discharge. When I saw her, her temperature was 103°, pulse 120, abdomen very much swollen and very tender. The finger could be introduced into the uterine cavity, but no tent was found. An opening in the wall of the cervix was discovered, and through this the tent was felt in Douglas' cul de sac. It was removed through this opening, and was found to be about the size of one's little finger. An opening was made into the cul de sac and a drainage tube put in. The uterus and vagina were washed out with 1-4000 bichloride. There was a temporary improvement, but she finally died 36 hours after I first saw her.

The woman maintained to the last that she introduced the tent herself, and this is probably true, considering the direction in which it was forced.

## Correspondence.

*Editor of THE CANADIAN PRACTITIONER:*

SIR,—In your issue last month I noticed that Dr. Seibert has again come to the front; not, however, to reply to my questions relative to the local origin of diphtheria, which he acknowledges he is incompetent to do, but rather to hurl at me some contemptuous remarks for

even daring to question the principle of his sub-membranous injection, and, like many others, I presume considers every person a fool who dares to differ from him. In your issue of February 16 will be found a communication by Dr. Greig, of Toronto, who says: "My opinion is that it is based on wrong principles, but we will wait and watch." Although Dr. Greig believes in the local origin of diphtheria, he does not yet believe in the principle of submembranous injection. Dr. Seibert very adroitly hides himself behind the volumes of Klebs, Loeffler, Oertel, and Heubner, saying to me, "Search these. I know nothing about it; they say so, and I believe them." Well, very probably they are correct; yet, to my mind, there is much yet to be explained in order to account for the various phenomena I enquired for. Now, not having received any satisfactory answers to my interrogatories, I beg leave to say that I shall not trouble you any more on the subject. Before closing, however, let me assure Dr. Seibert, of New York, that Dr. Benson, of Chatham, is not the fool he takes him for, nor is he so "entirely ignorant of ever the rudimentary portion of modern diphtheria pathology" as he thinks he is; and let me further advise him, when asked a question he cannot answer (as in this case), to keep cool and acknowledge his ignorance like a man, and not resort to mean, contemptuous, and sarcastic allusions to a person he knows nothing about, and who, I presume, can claim the privilege of asking for knowledge through your journals, even though he subjects himself to utter annihilation at the hands of Dr. Seibert. Thanking you for the space you have allotted to me, and assuring you that I shall not trouble you with any replies to any communication of Dr. Seibert unless he can deal in a more gentlemanly and professional spirit than his last displayed,

J. S. BENSON.

Chatham, June 29.

"JOHN McDUFFY, charged with vagrancy. What can you say for yourself?" "Not guilty, your honor." "What is your business?" "A professor of bacteriology." "Ten dollars and twenty days—no visible means of support."

## Personal.

At the recent meeting of the American Medical Association held in Detroit, Dr. John L. Bray, of Chatham, the president of the Canadian Medical Association, was formally introduced to the meeting and extended a cordial invitation to attend at our next meeting in Ottawa.

W. J. ASHLEY, M.A., who was for four years Professor of Political Science in Toronto University, has resigned to accept a similar position in Harvard.

DR. T. MITCHELL PRUDDEN, of New York, has been appointed Professor of Pathology in the Medical School of Columbia College.

DR. THORBURN has removed to his new residence on the corner of Spadina Road and Bloor Street.

DR. E. P. GORDON, whose leg was fractured in a football match in Vancouver, has returned to the city.

DR. HORACE BASCOM, of Uxbridge, was married, June 29.

DR. JOHN CAVEN is spending part of the summer at Cushing's Island.

## Therapeutic Notes.

TREATMENT OF INTESTINAL DYSPEPSIA.—(Leading Article, *Boston Med. and Surg. Journal*, March 17, 1892.) As this form of dyspepsia is generally, predominantly, a dyspepsia of starches, there is a leading indication to abstain from amylaceous and saccharine articles of diet. There should be a maximum of albuminoids—meat, eggs, fish—and a minimum of carbohydrates and fats. Brilliant results have been attained by a diet of raw meat—6 to 10 ozs. of lean beef or mutton, reduced to a pulp and cooked but slightly, if at all; to be eaten well seasoned with a little bread, but without vege-

tables. Thin slices of underdone roast meat, fresh broiled fish, raw oysters and other shell fish, soft boiled eggs, boiled ham, together with sour kraut, smoked herring, a little stale cheese, etc., have been recommended, the latter articles being particularly unlikely to undergo putrefactive decomposition. Chronic indigestion of this type is the result of long-continued dietetic errors, and in its treatment the dietetic plan marked out above should be adhered to as closely as possible. By way of medication, intestinal antiseptics is indicated, and is unquestionably of some service. For this purpose combinations of chalk, bismuth, magnesia, salol, salicylate of soda and naphthol are valuable. The patient may take after each meal a powder consisting of 5 grs. each of prepared chalk, magnesia, and salol, or 5 grs. each of salicylate of bismuth and naphthol. Nux vomica and columbo are also valuable. Diastases often are of service. Either malt or pancreatic diastases may be used. They are to be given during the meal. [They probably act by digesting the starch in the stomach, and favoring absorption of the resulting sugar before it reaches the intestine.] Laxatives often prove beneficial, but must be used judiciously, and with the single purpose of emptying the bowel of its fermenting contents. Rhubarb, senna, aloes, sulphur, cascara, and magnesia are among the best laxatives in this condition. Dr. G. B. Wood says: "The remedy which we have found most effective in the permanent cure of a disposition to the accumulation of flatus in the bowels is an infusion made with  $\frac{1}{2}$  oz. of columbo,  $\frac{1}{2}$  oz. of ginger, a drachm of senna, and a pint of boiling water, and given in the dose of a wineglassful three times a day."—*Journal American Medical Association*.

**OIL OF EUCALYPTUS.**—According to an American paper, more than 20,000 pounds of eucalyptus oil were exported to Europe from California in 1891, the popular belief as to its efficacy in influenza having probably created the demand. The beginning of the cultivation of the eucalyptus tree in California dates apparently no further back than 1869, in which year fifty acres in the neighborhood of Haywards were planted chiefly for lumber purposes. Since then enormous numbers of trees have been

planted. Some ten years ago it was discovered that a decoction of eucalyptus has the property of removing the scales of incrustation from boilers. The engineers engaged in preparing the fluid for this purpose noticed that those among them who suffered from bronchitis and asthma experienced considerable relief, the credit of which was, rightly or wrongly, assigned to the eucalyptus. From this incidental beginning, an important industry has since sprung up. Whatever may be the real or supposed virtues of eucalyptus in respiratory affections, however, it seems more probable that its sudden rise into popular favor during the influenza epidemic was chiefly due to its reputed antimalarial and microbicide properties.—*Brit. Med. Jour.*

A GERMAN physician has been subjecting the belief that cheese aids the digestion to a chemical test. Cheshire and Roquefort cheese took four hours to digest; genuine Emmenthaler, Gorgonzola, and Neufchatel, eight hours; Romondour nine hours; and Kottenberger, Brie, Swiss, and the remaining varieties, ten hours.—*College and Clinical Record*.

**A REMEDY FOR CHRONIC RHEUMATIC ARTHRITIS.**—According to Mr. Hugh Lane, in his recent work on "Rheumatic Diseases, the following prescription was found of such service among the pensioners of Chelsea Hospital who suffered from chronic rheumatic arthritis that Lord Anson gave three hundred pounds for the liberty to give publicity to it: R. Honey,  $\text{ʒxvj}$ ; sulphur,  $\text{ʒj}$ ; cream of tartar,  $\text{ʒj}$ ; rhubarb,  $\text{ʒiv}$ ; gum guaiaci,  $\text{ʒj}$ ; nutmeg, No. j. Misce. The patient took two tablespoonfuls in a small tumbler of hot white wine and water when going to bed, and the same quantity before rising in the morning, remaining in bed until any perspiration that was occasioned had subsided. The treatment was continued until a perceptibly good effect had ensued, when only one tablespoonful was administered at a dose until the mixture was used up.—*N. Y. Medical Journal*.

**ATROPINE IN BRADYCARDIA.**—In the *St. Petersburg Med. Wochens*, 1892, No. 1, Prof. Karl Dehio shows that by the use of atropine we can readily differentiate between the cases of

bradycardia due to vagus irritation and those of the automatic motor apparatus, since this remedy paralyzes the vagus ending in the heart; the four recorded instances show clearly that this method is a valuable one. In studying the association of such anatomical changes as fatty degeneration, fibrous myocarditis, sclerosis of coronary arteries, thrombotic myomalacia, he believes that these conditions are more often present without than with bradycardia. It was further noted that the older the individual the less was the acceleration which was produced by atropine.—*Amer. Jour. Med. Science.*

**SULPHUR IN THE TREATMENT OF CHLOROSIS.**  
—Prof. Hugo Schulz (*Med. Neuigkeiten*, No. 17, 1892) recommends sulphur in cases of pure chlorosis where iron has no action. In such cases the general condition is much improved by the use of sulphur. After this drug has been given for a time, the use of iron may be begun again and successfully carried out. On the contrary, it is not well borne in catarrhal and inflammatory states of the gastro-intestinal tract. The form of administration is:

R.—Flowers of sulphur - - - ʒ iʒss.  
Milk sugar - - - - - ʒ xxv.

Sufficient for ten powders. A knife-pointful three times a day.—*Cincinnati Lancet-Clinic.*

In the March number of the new *International Medical Magazine*, Dr. Buck says that while heat is one of the best remedies in painful inflammations of the middle ear and the poultice is one of the best methods of applying heat, as usually put on the poultice has little effect. What should be done, he says, is first to fill the external auditory canal with lukewarm water, the head resting on the unaffected side upon the pillow. Then a large flaxseed poultice is applied over the ear as hot as can be borne. The column of water is thus kept warm, and acts as a conductor of heat between the poultice and the inflamed surface.—*Northwestern Lancet.*

**TREATMENT OF SINGULTUS.**—Dr. Browne (*Deutsche med. Wochenschrift*, No. 21, 1892) has treated cases of singultus with success by washing out the stomach after medicinal treatment had been tried in vain. Dr. Leloir reports

in the French Academy of Sciences that he has successfully treated this affection by pressing the phrenic nerve at the clavicle, between the two divisions of the sterno-cleido-mastoid.—*Cincinnati Lancet-Clinic.*

**EFFICIENT REMEDIES IN DYSENTERY.**—The following we find in the *Medical World*: Copious antiseptic irrigations of the colon. Avoid nitrate of silver except in subacute or chronic cases.

Pulverized ipecac, given dry, in doses of twenty to sixty grains. Dover's powder may be substituted in some cases with advantage.

Bichloride of mercury, 1-1000 to 1-1100 grain hourly, in solution.

Sulphate of magnesia, with sulphuric acid, in sufficient hourly doses to produce catharsis.—*St. Louis Med. and Surg. Journal.*

**BLACKENING OF TEETH BY ANTIPYRIN.**—According to the *Southern Dental Journal*, it is asserted that the internal use of antipyrin blackens the teeth. This peculiarity should be generally known by the profession, and also among the laity, that objections may be made on this account to taking it as a remedy. The blackening is the more intense the more imperfect the enamel, but may be removed by attrition with dilute acid. The considerable use of antipyrin for several years back gives importance to this latter observation.—*Weekly Medical Review.*

**SYRUP FOR INFANTILE CONSTIPATION.**—

R.—Podophyllin - - - gr. j.  
Alcohol - - - - - dr. iss.  
Syrup of red raspberry ʒ iij.

M. Dose—From a teaspoonful to a dessert-spoonful every morning, according to the obstinacy of the constipation.—*L'Union Medicale.*

**DIARRHŒA.**—

R.—Salol - - - - - dr. ij.  
Bismuthi subnitratis - ʒiv.  
Mist. cretæ - - - q. s. ad. ʒiij.

M. Sig. One teaspoonful every two hours.—*Buffalo Med. and Surg. Jour.*

**OBESITY.**—A French journal recommends a mode of dieting for curing obesity, which is attributed to an army doctor. A colonel, who was threatened to be retired from the army, as he was so heavy that it required two men to lift him into the saddle, became thin in a few weeks, and to such extent that he had to take means to recover what he had lost. The means consisted simply in not eating more than *one* dish at any meal. It is said by doing this the stomach never takes too much. Nevertheless nothing but the one dish should be taken; no condiments or soups or supplementary dessert should be allowed.—*Med. and Surg. Reporter.*

**AMYL NITRITE FOR AFTER-PAINS.**—I have had several cases in which the pains were exhaustingly severe, and in which I was glad to turn to nitrite of amyl. This potent drug is a very efficient controller of after-pains, and, used cautiously, I see no reason to apprehend harm from it. A neat way to use it is to saturate a small piece of tissue paper with five or six drops, stuff this into a two-drachm vial, and request the patient to draw the cork and inhale the odor when she feels the pain coming on. It acts with magical celerity.—*Dr. Winterburn in Journal of Obstetrics.*

**A USEFUL** lotion for sprains, erysipelas, and burns is made by mixing together rectified spirit, 3 fluid drachms; solution of acetate of lead (B.P.), 2 fluid drachms; and distilled water, 6 fluid ounces. Linen cloths wet with this lotion are kept applied to the part affected, and changed as often as they become warm or dry.—*Magazine of Pharmacy.*

**CALOMEL** is recommended by Dr. J. B. James, of London, as an excellent topical application for hemorrhoids. It is said to relieve all pain and uneasiness, and enables the patient to attend to his usual business without inconvenience.—*Medical Fortnightly.*

**VERATRUM VIRIDE** is highly recommended for the palpitations and hot flashes of the climacteric.

## Miscellaneous.

**THE DOCTOR AND THE HOTEL CLERK.**—A good story is told of the late Dr. Thayer, of Burlington, concerning his experience at a hotel in Cincinnati, where he stopped while attending a National Medical Congress many years ago. Arriving somewhat late in the evening, he went immediately to bed. Upon inspecting his bill before leaving, Dr. Thayer saw he was charged for a supper the night of his arrival, and inquired as to same, saying he had had no supper that night. "But," the clerk said, "you were here; you *might* have had it." "Oh, well," said the doctor, "I can fix that," whereupon he immediately made out a bill against the hotel for medical services, the amount covering the charge for the supper. Upon presenting the same to the clerk, the latter said: "Doctor, I was not aware we had called on you for professional service." "Oh, no," said Dr. Thayer, "but I was here, and you *might* have done so." The procedure, being so original, so pleased the proprietor that he presented Dr. Thayer with his whole bill, and asked him cordially to make him a visit in the future.—*Dr. J. H. Linsley in Medical Record.*

A **NOTABLE** instance of the tendency towards specialization in business is offered by the recent action of the long-established drug house known as Stewart W. Johnston, of this city. Observing the already great and rapidly increasing number of specialties for the use of the physician being turned out by the large manufacturers, Mr. Johnston conceived the idea of aggregating all these articles under one roof, and for this purpose disposed of his retail business and organized a joint stock company with headquarters at No. 200 King street west, where they are prepared to fill orders for recent pharmaceutical combinations, new remedies, absorbent dressings, fine chemicals, etc., etc. The Messrs. Johnston invite correspondence.

**THE RESIDUARY LEGATEE.**—A very curious case was recently tried at Bolton, in Lancashire, and a decision arrived at which will be interesting to hospital surgeons. A farmer sued the house surgeon of the Bolton Infirmary for £10.



the value of the leg of his son, who had been a patient in the infirmary, and from whose body corporate the limb had been amputated. The boy died, and the father claimed as heir at law, the interesting question being discussed whether administration of the estate of the boy had been taken out. In the end it was decided, as in conformity with a previous decision, that there is no property in a derelict limb, and the farmer therefore failed to recover the cadaveric valuable.—*Med. Press.*

A ROYAL LADY MEDICAL STUDENT.—A Royal Princess is studying medicine at the Rangoon Hospital. She is the granddaughter of the late Mindoon Min, King Theebaw's predecessor, and she is desirous of making herself qualified to work as a doctor amongst her countrywomen. She was rescued from captivity with the other members of the king's family on the British occupation in 1885. The Princess is reported to be very clever and accomplished.

SYPHILIS A BAR TO MARRIAGE.—The Court of Appeals of Kentucky have recently decided

that syphilis, pleaded in answer to an action to recover damages for breach of promise of marriage, is a complete defence, following the decision of the Supreme Court of the State of North Carolina, in which the same defence was interposed and sustained in a similar action.—*Weekly Medical Review.*

HARVARD MEDICAL SCHOOL has adopted a compulsory four years' course which will be required from all who enter next fall. Students in classical and scientific schools in which courses in anatomy, physiology, and chemistry are taught will be admitted to advanced standing on passing an examination.

THE sixth annual meeting of the American Orthopedic Association will be held in the New York Academy of Medicine, September 20th, 21st, and 22nd, 1892.

THE CANADIAN PRACTITIONER is printed for the Publisher by MESSRS. BROUGH & CASWELL, 14 to 18 Bay St., Toronto. Messrs. Brough & Caswell make a specialty of fine office stationery for Physicians' use, and of announcements, calendars, etc., for medical institutions. Correspondence solicited.

# UNIVERSITY OF THE CITY OF NEW YORK.

MEDICAL DEPARTMENT.

No. 410 East 26th St., opp. Bellevue Hospital, New York City.

FIFTY-SECOND YEAR, 1892-93.

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The FIRST YEAR comprises recitations in primary subjects, dissection, laboratory work, urine analysis, etc.

The SECOND YEAR comprises lectures in the primary branches, recitations, laboratory work, and clinics in general medicines and surgery.

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For further particulars and circulars address the Dean,

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